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# MONTANA HEALTH AGENDA 2000

Montana's
Healthy People 2010
State Plan

## Montana Department of Public Health & Human Services

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# EXECUTIVE SUMMARY

Individuals alone cannot ensure their own health or the health of their community. For state and local governments, addressing the health issues of the 21st Century requires planning with community partners, legislators, state and local health professionals and others so that a collective responsibility for the public's health can be envisioned.

Through the *Montana Health Agenda 2000*, the Montana Department of Public Health and Human Services (DPHHS) presents a comprehensive leadership plan to accomplish key health priorities for Montana. The Agenda identifies why the process was undertaken and describes how a health agenda can assist:

- the people of Montana to learn about leading health problems, risk factors, and causes of death;
- the policy makers to know more about why a particular problem is important, what progress has been made, and what remains to be accomplished, including emerging problems;
- the providers of health care and other professionals to discern and perhaps expand their role in prevention; and
- the partners who help move the health agenda forward to realize how their unique roles contribute to the success of the whole agenda.

*The Montana Health Agenda 2000* revises the 1998 Montana Health Agenda in significant ways:

- the nation's Healthy People 2010 (HP 2010) objectives have been incorporated;
- baseline information has been added, when available, to assist in measuring progress toward meeting the Montana objectives; and
- new priority areas have been added which reflect emerging health risks and leading causes of death.

Not all of the Leading Health Indicators of Healthy People 2010 are included in the *Montana Health Agenda 2000*. The emphasis currently undertaken by the DPHHS Health Policy & Services Division in collaboration with local health departments, including tribal health services and Indian Health Service, and other community partners is highlighted. Other Divisions within DPHHS, as well as other Departments, including the Montana Department of Environmental Quality, and non-profit health organizations, have responsibilities for other health indicators and the reader is referred to those entities.

Montana's health priorities are:

- Access to Health Care
- Cancer Prevention
- Cardiovascular Health
- Child & Adolescent Health
- Diabetes
- Emergency Medical Services and Statewide Trauma Systems
- Environmental Epidemiology
- Food Safety
- HIV/AIDS Treatment
- Immunizations
- Information Access & Security
- Injury Prevention
- Oral Health
- Public Health Improvement
- Public Health Laboratory Services
- Sexually Transmitted Diseases
- Suicide Prevention
- Tobacco
- Women's Health & Pregnancy

**Each priority has an impact on human life,** and many priorities have associated "risk factors" that contribute to early death or disability, and can be modified or eliminated. Minority populations are frequently overrepresented in deaths and morbidity from disease or other conditions. As examples,

- A person who is overweight or obese is at greater risk for hypertension, high cholesterol, type 2 diabetes, heart attack, and stroke. A sedentary lifestyle is also a common health risk behavior among Montana adults.
- The National Cancer Institute estimates that up to 50% of cancer deaths could be avoided through the widespread use of proven techniques for prevention, early detection and state-of-the-art treatment.

Tobacco causes many diseases.

- Cigarette smoking causes heart disease, several kinds of cancer (lung, larynx, esophagus, pharynx, mouth and bladder) and chronic lung disease, and contributes to other cancers.
- Spit tobacco causes a number of serious oral health problems, including cancer of the mouth and gum, periodontitis, and tooth loss.
- Smoking during pregnancy causes spontaneous abortions, low birth weights, and sudden infant death syndrome (SIDS).
- Nonsmokers suffer deadly consequences from exposure to secondhand smoke.

**Leading causes of death,** as compiled from death certificates, show that Montanans, as a whole, die most frequently from heart disease, cancer, cerebrovascular disease, chronic obstructive pulmonary disease, and accidental deaths due to unintentional injuries. Heart disease and cancer rates are lower than national rates, but far exceed the risk of death from other causes.

- For Montana Native Americans, accidents, diabetes and chronic liver disease and cirrhosis follow heart disease and cancer as leading causes of death.

Montana rates for traumatic causes of death, accidents and suicide, were higher than those for the nation the past ten years.

- Motor vehicle crashes are the leading cause of injury and fatality in Montana from ages 1-44. 47.9% of fatal crashes in 1999 were alcohol-related.
- Montana's overall suicide rate is among the highest in the nation. Suicide is the 2$^{nd}$ leading cause of death for Montanans between the age of 10-34 and the 8$^{th}$ leading cause of death in Montana for all ages. Firearm-related suicide continues to be the leading cause of suicide in Montana.

Many conditions are preventable or have less severe consequences if dealt with early. A few examples follow:

- Sexually Transmitted Diseases (STDs) are the most commonly reported communicable diseases in Montana, with *Chlamydia trachomatis* being the most common.
- Early identification and management of hearing impairment, beginning in infancy, assures timely development of speech and oral language skills, and helps minimize the impact of hearing loss.
- Fetal Alcohol Syndrome/ Fetal Alcohol Effect is recognized as the leading cause of mental retardation and neurological dysfunction, yet it is 100 % preventable.
- Most food-borne illnesses can be prevented, thus alleviating the large costs associated with lost productivity and treatment of infected persons.
- Teen pregnancy is still a crisis despite rate decreases.

- Unintended pregnancy is of great concern -- nationally, 49% of all pregnancies are unintended. Unintended pregnancies tend to become high risk pregnancies, with potential for low birthweight infants, infants with disabilities, or infants who do not survive their early years.

**Other conditions** are increasing in magnitude and in their role as public health concerns. Some examples are:

- Access to dental services is at crisis levels for the poor, uninsured and underinsured who tend to suffer from disproportionate levels of oral health problems.
- Asthma is one of the most common chronic diseases of childhood, with children under 5 years old experiencing the highest increase in incidence of disease.
- Diabetes prevalence is increasing. An estimated 54,000 Montanans (6.8% of the population) have diabetes: 4.1% have diagnosed diabetes and approximately 2.7% have undiagnosed diabetes.
- Domestic violence continues to grow in scope.

**Access to Health Care**

A maldistribution of health care providers poses access problems for some Montanans. Larger population centers have adequate numbers of primary care providers and accessible specialty care, especially for those with health insurance. Nine counties have no physicians and eleven counties have no dentists. Nurse practitioners, including nurse midwives, are underutilized across the state. Physician Assistants are the primary health providers in areas of the state with CAHs and Rural Health Clinics (RHC). However,

- Forty-nine of 56 counties have a shortage of health care providers.
- 93% of counties provide public health services, with departments that range in size from a large system (including primary care services for the under-served population as well as traditional population-based public health services including environmental services) to the limited, part-time provision of services by one or two public health nurses.
- Montana ranks 44$^{th}$ of 50 states in the percent who are insured.
- Montana ranked 50$^{th}$ (68.4%) compared to the average nationwide of 83.1% of employees working in private businesses offering insurance.
- DPHHS estimates that 10,000 children of low-income working parents in Montana will have no health insurance coverage or health plan even when CHIP is fully implemented.
- Montana ranks 42$^{nd}$ in the nation for population in Health Maintenance Organizations (HMOs), thus the penetration continues to be small. The Montana Medicaid HMO that had operated in Billings and Great Falls was discontinued July 1, 2000. The approximately 2000 enrollees in the HMO have moved to the statewide Passport to Health program where they will continue with their same primary care providers.
- The public health system is fragmented. Threats to the public's health from natural disasters, emerging infections, chronic diseases, and environmental health are on the rise. To address these challenges, Montana needs a strong, coordinated public health system.
- City, county, and state health professionals currently must use more than 15 separate data systems for information about services and clients of Montana's public health programs and Medicaid. Timely reporting suffers because data are not readily available.

All hospitals, with the exception of those in Billings and Great Falls, are classified as rural facilities by the Health Care Financing Administration (HCFA). Montana has 62 licensed hospitals – 48 are not-for-profit

acute care community hospitals, and 15 are Critical Access Hospitals (CAHs) with limited services usually provided by midlevel practitioners. Thirty-two of the 48 hospitals delivered babies in 1999.

- Establishment of Rural Health Clinics (RHC) has improved access to health care in many counties and communities. Twenty-nine RHCs have been established; several additional sites currently considering conversion to/establishment of a RHC. In counties with a CAH, the addition of a Rural Health Clinic has served the dual purpose of increasing access to primary care services and improving the financial position of the CAH.
- Community Health Centers (CHC) are located in Billings, Butte, Missoula, Helena, Great Falls, and Livingston. In all locations but Butte and Livingston, the CHC is co-located with the local public health department.
- Migrant Health services have been provided over the last several years in six locations in eastern Montana and in the area around Flathead Lake. Over 12,000 migrant workers and their families receive services each year.
- Montana's Emergency Medical System (EMS) and trauma system serves as a "safety net" for the rest of the health care delivery system. The scarcity of medical resources in rural areas, combined with long emergency transport distances, makes the availability and careful integration of an excellent EMS and trauma system even more strategic in reducing preventable injury mortality

Montana also has a vast network of nonprofit health-focused agencies, extension services, and others who are part of the solution to preventing many of Montana's leading causes of death and moving others towards prevention. A partial listing of these agencies and organizations appears in the Appendix.

The state of the State's health is influenced by many major factors other than diseases, lifestyles, and access to health care providers. A fluctuating economy (which is partially responsible for Montana's ranking of 5$^{th}$ in the U.S. for number of people living in poverty), diverse geography, weather, and travel conditions, along with a frontier spirit, all have an impact on Montana's health.

The fact that Montana is home to the nation's largest Superfund site complex may have impacts we have yet to consider. There are 225 Superfund sites in Montana; 13 are on the National Priority List. Toxic substance releases have occurred at sites where mining, smelting, wood-treating, railroad fueling & degreasing, petroleum refining, land filling, and chemical manufacturing/storage activities have been conducted. Contamination of air, surface water, ground water, sediments, and soils at these sites may pose serious human health problems.

As partners, we must think differently about our approaches to prevention. We must coordinate our efforts, and challenge ourselves to take risks that will ultimately improve the health of Montana's future generations. Additional information about the Health Policy & Services Division programs, and Montana's counties (including county profiles) can be obtained from the DPHHS Health Policy & Services Division website: www.dphhs.state.mt.us/hpsd/.

# OVERVIEW

## WHY DEVELOP AN AGENDA FOR HEALTH?

Individuals alone cannot ensure their own health or the health of their community. The health of a community is a shared responsibility of many entities, as well as a personal responsibility of each community member. For state and local governments, addressing the health issues of the 21st Century requires planning with community partners, legislators, state and local health professionals and others so that a collective responsibility for the public's health can be envisioned.

Developing an agenda for health offers the opportunity to:

- use the wisdom and expertise of local, state, and national experts who deal with public health issues on a daily basis;
- examine trend data (such as the fact that by 2025, Montana is expected to have the 3rd highest proportion of elderly in the nation) and increase or modify planning efforts;
- begin to identify emerging health issues and to plan for them;
- reaffirm the need for doing "what works" — not becoming complacent and reducing efforts [and funding] because rates have either increased or dropped; and
- revisit what has been done to evaluate effectiveness, make changes as necessary, and communicate findings to policy makers and the public.

The Montana Department of Public Health and Human Services (DPHHS) [and its predecessors] has fulfilled its role in addressing and solving health issues for Montanans for nearly 100 years. It takes its mission seriously:

*TO IMPROVE AND PROTECT THE HEALTH AND SAFETY OF ALL MONTANANS.*

Accomplishing the mission is best achieved by working with many state and local community partners and involving them in determining the direction that will meet the current challenges. The Montana Health Agenda is one tool among many, but serves as a guide for the next several years in accomplishing health priorities for Montana.

*The Montana Health Agenda 2000* revises the 1998 Montana Health Agenda in the following ways:

- Objectives, some of which were previously unmeasurable, have been reworded to become measurable, and many incorporate the national Healthy People 2010 Health Objectives [1] (HP 2010).
- Five new areas, including Tobacco and Oral Health, have been added.
- Some titles have been changed in an effort to clarify the content included, and at least some areas of similar interest that were previously separate have been combined.

Each priority area was developed around the following four elements.

| | |
|---|---|
| • Goal and Objectives | Include HP 2010 Objectives, where applicable |
| • Why It's Important | Background information, including health status |
| • What Montana Has Accomplished | Milestones achieved |
| • What Still Needs to Be Done | Action needed to improve health status or accomplish goal |

Since 1979, the federal government has convened public health and other experts to advise the nation on improving the nation's health. The 1979 publication, *Healthy People: The Surgeon Generals Report on Health Promotion and Disease Prevention*, provided national goals for reducing premature deaths and preserving independence in older adults. In 1980 and 1990, respectively, targeted health improvement goals and objectives were identified for accomplishment in the succeeding decades. HP 2010 continues this custom with goals to improve health in the first decade of the 21st century.

**LIMITATION**

*Montana's Health Agenda 2000* does not encompass all of the Leading Health Indicators included in HP 2010. This limitation was self-imposed by the Health Policy & Services Division, which has programmatic and fiscal responsibility for a major portion, but not all, of the leading health indicators. The document reflects the emphasis currently undertaken by the State of Montana through state and local health departments, including tribal health services and Indian Health Service, Billings Area Office, and other community partners. Resources within jurisdictions may permit additional or other areas of emphasis.

Other Divisions within the Montana Department of Public Health & Human Services, as well as other Departments, including the Montana Department of Environmental Quality, and non-profit health organizations, have responsibilities for other health indicators and the reader is referred to those entities. The HPSD fully recognizes the interrelationship between physical health and mental health. For information regarding the Addictive and Mental Disorders Division, please visit their website at: **http://www.dphhs.state.mt.us/divisions/amd/amd.htm**

## WHO NEEDS A HEALTH AGENDA? [2]

The Montana Healthy People 2010 Health Agenda provides a wealth of information for all segments of Montana, including

- the people of Montana;
- the policy makers;
- the providers of health care and other professionals; and
- those with whom state and local agencies form partnerships to move the health agenda forward.

## ✦ PEOPLE OF MONTANA

Virtually every Montanan is affected in some way by one or more of the priority issues of the Montana Health Agenda. As individuals, Montanans can use the Health Agenda to learn about risk factors and preventable causes of death or about other health issues that may impact their neighbors and friends.

### *Risk Factors for Montanans* [3]

To fulfill their personal responsibility for health, Montanans need more information about their health risks so that they can take steps to reduce or avoid unhealthy behaviors and conditions. As a rule, Montanans tend to be healthier than the average U. S. resident, although there are some noteworthy differences.

Compared to the U. S. as a whole, for Montanans:

- Being overweight, consuming alcohol and/or tobacco, and having a poor diet places one at increased risk of heart disease. A sedentary lifestyle is also a common health risk behavior among Montana adults.
- Heart disease and cancer rates are lower than national rates, but far exceed the risk of death from other causes.
- Minority populations are overrepresented in deaths and morbidity from disease or other conditions.
    - Whites typically die at an older age than Native Americans do.
    - One quarter of white persons died at or below age 65, while one fourth of Native Americans died at or below age 40.
    - The median age for death of white women was 80; for Native American women, it was 65 years.
    - The median age of death of white men was 74 and for Native American men, it was 58 years.
- Montana's age-adjusted rate for diabetes, Alzheimer's, and Chronic Obstructive Pulmonary Disease (COPD) including bronchitis, emphysema, asthma, and related diseases are notably higher than those of the U. S. Montana's death rate from diabetes was higher than that of the U. S. for four of the past ten years, and COPD was higher for all ten years.
- The rates for traumatic causes of death, accidents, and suicide were higher than those for the nation the past ten years.
- The violent crime rate is of concern. While it continues to rank 46th in the nation in magnitude, Montana has the fifth fastest growing rate in the country. Montana ranks 27th in the nation for murders.
- Rates for chlamydia have not declined in the last 3 years.
- Teens are more likely to use tobacco, especially smokeless tobacco.
- Teen pregnancy rates are decreasing and teens report being slightly less sexually active.
- Gonorrhea rates have declined dramatically.
- The number of AIDS cases continues to decrease, due in large part to the effective treatments that are currently available. However, new HIV infections continue at the same rate.
- The proportion of women receiving early prenatal care is increasing.
- White women are more likely to have early prenatal care than non-white women are. A notable exception is that women whose pregnancy care is provided through Indian Health Service consistently receive earlier, more adequate care than other non-white Montana women.

*Preventable Health Problems*

Leading causes of death in Montana, as compiled from death certificates, for the population as a whole are heart disease, cancer, cerebrovascular disease, chronic obstructive pulmonary disease, and accidental deaths due to unintentional injuries. For Montana Native Americans, accidents, diabetes and chronic liver disease and cirrhosis follow heart disease and cancer as leading causes of death. These have remained the same for several years. This information is presented in table form below.

| Leading Causes of Death of Montanans | |
|---|---|
| **All Montanans** | **Native Americans** |
| Heart disease | Heart disease |
| Cancer | Cancer |
| Cerebrovascular disease | Unintentional injuries |
| COPD | Diabetes |
| Unintentional injuries | Chronic liver disease and cirrhosis |

Domestic violence continues to grow in scope. Public health nurses responding to the annual spring needs assessment survey have ranked domestic violence in the top five public health needs for the past several years.

A DPHHS study conducted in 1998[4] collected anonymous information from women visiting county health departments, WIC clinics, family planning clinics, and private practice office throughout the state. Women presenting for health care or bringing a family member for health care were asked to complete a questionnaire anonymously, place it in a sealed envelope, and place the envelope in a locked box. A total of 1,970 questionnaires were completed.

Demographics of the respondents reflected those of the state in regard to race or ethnicity. Over 92% of the women had completed 12 or more grades of school. At the time they completed the questionnaires, 10.6 % of the women were pregnant, 35.8% said they smoked, 51% used alcohol, and 9.4% used street drugs. Twenty-one percent of the women had been fearful of being hurt at some time, with 16.2% being fearful within the past year. Thirty percent had been emotionally abused and 18.5% had been physically abused. Homicidal ideation was found in 9% and suicidal ideation in 16.6%. The seriousness of the problem is underscored by the high rates of homicidal and suicidal ideation.

*Leading Causes of Death by Age Group*

The table which follows presents data about leading causes of death by age groups for the United States as a whole, and for Montana. Where further detail is available for Montana, it is included. The leading causes of death are the same for both populations, U. S. and Montana, for children ages 1 – 4; for adults 45 – 54 years of age; and for adults who are 85+ years old. Of note is the young age at which suicide becomes a leading cause of death for Montanans. Caution should be taken when using the data for Montana because of the small number of incidents.

## Leading Causes of Death by Age Group[5]

| Age Group | United States 1997* | Montana 1998* | |
|---|---|---|---|
| Younger Than 1 Year | • Birth Defects<br>• Disorders Related To Premature Birth<br>• SIDS | • Birth Defects<br>• Conditions Related To Early Infancy<br>• SIDS | |
| 1 – 4 Years | • Unintentional Injuries<br>• Birth Defects<br>• Cancer | • Unintentional Injuries<br>• Birth Defects<br>• Cancer | |
| 5 – 14 Years | • Unintentional Injuries<br>• Cancer<br>• Homicide | • Unintentional Injuries<br>• Suicide<br>• COPD / Diabetes (Tied) | |
| 15 – 24 Years | • Unintentional Injuries<br>• Homicide<br>• Suicide | • Unintentional Injuries<br>• Suicide<br>• Homicide & Legal Intervention | |
| 25 – 44 Years | • Unintentional Injuries<br>• Cancer<br>• Heart Disease | • Unintentional Injuries<br>• Suicide<br>• Cancer [Ages 25-34]<br>• Heart Disease [Ages 35-44] | |
| 45 – 64 Years | • Cancer<br>• Heart Disease<br>• Unintentional Injuries | • Cancer<br>• Heart Disease<br>• Unintentional Injuries [Ages 45-54]<br>• COPD [Ages 55-64] | |
| 65 Years and Older | • Heart Disease<br>• Cancer<br>• Stroke | [Ages 65-74]<br>• Cancer<br>• Heart Disease<br>• COPD | [Ages 75-84]<br>• Heart Disease<br>• Cancer<br>• COPD |
| | | [Ages 85+]<br>• Heart Disease<br>• Cancer<br>• Cerebrovascular Disease | |
| * Latest year for which data are available | | | |

***Underlying Causes***

Many reasons could be listed for the state of the State's health. Diverse geography, a fluctuating economy, and a frontier spirit all contribute to what one does about one's health. A high poverty rate (Montana is listed as 5th in the country for percent of the population in poverty; our child poverty rate ranks 9th nationally, based on the 1999 Federal Poverty Level)[6] along with a high unemployment rate among those living on the reservations only add to the problem.

Montana's overall unemployment rate in 1999 was 5.2, ranking 11th in the nation, with the reservations' unemployment rate in excess of 18% for four of the seven reservations. Only the Flathead, Fort Peck, and Crow reservations had unemployment rates lower than 15%.[7]

The 1990 population of Montana was 799,065. By 1999, the population had risen to 882,779, an increase of 10.5% or almost 84,000 people, The population density is 6.1 person per square mile, split almost equally between urban (52.5%) and rural (47.5%). The racial and ethnic breakdown of the population remains consistent with 92.7% Caucasian; Native Americans are our most significant population minority at 6%.[8] Minority populations are consistently overrepresented in statistics regarding health status and death.

## ✦ POLICY MAKERS

Policy makers include state and local public health officials, elected officials, legislators, business leaders, faith leaders, researchers, and others, including those who respond to requests for information and fill out surveys.

Nationally, elected and appointed officials and others also contribute to policies within our state. These people are key players in helping to develop a planned approach to reverse trends of poor health and to coordinate prevention activities. A state health agenda can be helpful to policy makers in the following ways:

- Identifying priorities that need a coordinated, statewide approach, as well as those that can best be solved in communities and neighborhoods;
- Gaining helpful information about successes and problems in ongoing programs;
- Determining needed budgetary support;
- Determining priorities for staffing; and
- Developing a prevention agenda.

## ✦ PROVIDERS AND OTHER PROFESSIONALS

### *Primary Care Providers*

Accessibility to primary care givers is inconsistent across the state, with nine counties having no private medical services at all. Larger population centers have adequate numbers of primary care providers and accessible specialty care, especially for those with health insurance. Rural areas fare much more poorly. Small hospitals are converting to Critical Access Hospital (CAH) status that limits access to critical and sophisticated care when it is needed quickly. Older physicians and dentists nearing retirement may find it difficult to recruit providers interested in taking over their practices.

There are an estimated 572 active primary care physicians with a total of 1,843 total physicians licensed in Montana.[9] Sixty percent of the primary care physicians are located in Silver Bow, Yellowstone, Missoula, Gallatin, Cascade, Lewis and Clark and Flathead counties, the seven most populated counties in Montana. Recruitment of physicians to staff the smaller hospitals in Montana continues to be a critical problem.

Nurse practitioners, including nurse midwives, practice in a variety of settings, including private practice. Approximately 251 nurse practitioners and 28 certified nurse midwives were licensed in the state as of December 1999. Their acceptance by physicians and use by the public varies from county to county. In public health, nurse practitioners are most likely to be employed by larger health departments and family planning clinics.

An estimated 465 active dentists are licensed in Montana. Eleven counties have no dentists and, as with physicians, the majority of dentists practice in the more populous areas of the state.

Physician Assistants are the primary health providers in areas of the state with CAHs and Rural Health Clinics (RHC). Approximately 135 are licensed in Montana.

### *County Health Departments*

County health departments are central to the provision of public health services in Montana. Of the 56 counties in Montana, 93% provide public health services. Public health departments range in size from a large system (including primary care services for the under-served population as well as traditional population-based public health services including environmental services) to the very small, limited, part-time provision of services.

Four counties (Carter, Golden Valley, Musselshell, and Petroleum) have no public health nurse; sanitarian services are available in all counties, with a number of counties sharing sanitarians with neighboring counties. The pool of trained public health nurses is very small, and recruitment continues to be a problem. The loss of just one nurse significantly impacts the delivery of services to the population.

### *Hospitals*

Montana has 62 licensed hospitals – 48 are not-for-profit acute care community hospitals, and 15 are Critical Access Hospitals (CAHs) with limited services usually provided by midlevel practitioners. All hospitals provide access to care for low income, indigent, Medicaid, and Medicare patients. In most communities, the hospital is the center of the provision of health care as well as being an important economic resource. Two hospitals provide pediatric mental health care, and five provide care exclusively for veterans and Native Americans and are federally owned and operated. An outpatient facility at Malmstrom Air Force Base in Great Falls serves military personnel and their families.

All hospitals, with the exception of those in Billings and Great Falls, are classified as rural facilities by the Health Care Financing Administration (HCFA). Thirty-two of the 48 hospitals delivered babies in 1999. Billings, Missoula, and Great Falls have hospitals classified as "level III" centers for perinatal purposes. Thirty-nine hospitals are considered sole community providers, and four are rural referral centers. Forty-five hospitals and CAHs also provide long-term care services. Maintenance of facilities and recruitment and training of personnel are ongoing problems.

### *Rural Health Clinics*

Establishment of Rural Health Clinics (RHC) under the provisions of PL. 95-210 has improved access to health care in many counties and communities. There are 29 Rural Health Clinics in Montana and several additional sites currently considering conversion to/establishment of a RHC. Some are in counties with no hospitals and no physicians. In counties with a CAH, the addition of a Rural Health Clinic has served the dual purpose of increasing access to primary care services and improving the financial position of the CAH.

*Community Health and Migrant Health Centers*

Community Health Centers (CHC) are located in Billings/Yellowstone County, Butte/Silver Bow County, Missoula/ Missoula County, Helena/Lewis and Clark County, Great Falls/Cascade County and Livingston/Park County. In all locations but Butte and Livingston, the CHC is co-located with the local public health department. CHCs are required, by federal regulations, to provide primary care services (on a sliding fee scale) to all persons seeking health care.

One Migrant Health Center (MHC) is located administratively in Billings. Satellite services have been provided over the last several years in six locations: Fairview/Richland County, Glendive/Dawson County, Bridger/Carbon County, Flathead-Lake Counties, Hardin/Big Horn County and Hysham/Treasure County. This year, services are expanding to Beaverhead and Madison Counties. In 1999, these centers served an estimated 12,400 migrant workers.

*Managed Care*

Montana ranks 42nd in the nation for population in HMOs, thus the penetration continues to be small. The Montana Medicaid HMO that operated in Billings and Great Falls for the past four years was discontinued effective July 1, 2000. DPHHS and the HMO mutually decided that, with enrollment lower than expected and with increasing federal regulations, it is no longer feasible to continue to offer this Medicaid option. The approximately 2000 enrollees in the HMO have moved to the statewide Passport to Health program where they will continue with their same primary care providers.

## ✦ PARTNERSHIPS FOR PUBLIC HEALTH DECISION MAKING

Based on the notion of shared responsibility for health, the Montana Turning Point initiative seeks to impact health at the community level through active participation of physicians, public health professionals, business leaders, state government, faith leaders, and other community partners.

As partners, we must think differently about our approaches to prevention. We must coordinate our efforts, and challenge ourselves to take risks that will ultimately improve the health of Montana's future generations.

In addition to the providers and other partners mentioned above, Montana has a vast network of nonprofit health-focused agencies, extension services, and others who are part of the solution to preventing many of Montana's leading causes of death and moving others towards prevention. A partial listing of these agencies and organizations appears in the Appendix.

Additional information about the Health Policy & Services Division programs, and Montana's counties (including county profiles) can be obtained from the DPHHS Health Policy & Services Division website: www.dphhs.state.mt.us/hpsd/.

# PRIORITIES FOR A HEALTHY MONTANA

# ACCESS TO HEALTH CARE

## GOAL AND OBJECTIVES

**Assure that all Montanans have access to basic health care.**

- By 2002, increase by 10 percent the number of Well Child visits for PASSPORT Managed Care children in the 3 – 6 year age group.
- By December 31, 2000 enroll the current capacity level of 9,725 children in the Children's Health Insurance Plan (CHIP).
- By December 31, 2002 expand Passport to Health from 52 to 55 counties.
- During each year of the biennium, place 60 medical residents/students in medically underserved areas of Montana through the National Health Service Corps (NHSC) Student/Resident Experiences and Rotations in Community Health (SEARCH) program.
- On an ongoing basis, identify all primary care, dental and mental health areas in Montana that could benefit from federal shortage designations, and assist communities to apply for programs to improve health care access.
- On an ongoing basis, develop strategies, policies, and expansion of safety net providers to achieve 100% access for all Montanans and 0% disparities.
- By 2010, assure that 90% of pregnant women have access to prenatal care during the first trimester. (1999 Baseline: 83.6% of infants were born to women who received prenatal care during their first trimester.)[10]

**Strong predictors of access to quality health care Include health insurance, adequate income, and a regular primary care provider or other source of Ongoing health care.**

*Not understanding the need for and availability of preventive health services limits their appropriate use. The uninsured are at least twice as likely as those with private insurance to be hospitalized for avoidable complications of conditions such as diabetes and hypertension—problems that could be managed in a doctor's office.*

## WHY IT'S IMPORTANT

- Good health is a key determinant of the economic security of families and the educational achievement of children.
- Good health enables parents to work and care for their children, and it allows children to attend school and develop their full potential.
- Montana is 5th in the U.S. for number of people living in poverty. [11] 17.2% of the population is at or below 100% of the Federal Poverty Level and 43.2% are at 200% of the Federal Poverty Level. [12]
- Montana ranks 44th of 50 states in the percent who are insured.
- 19.6% of Montanans were uninsured in 1998, an increase of nearly 35 percent in the past five years. This compares to a national average of 16.3% uninsured rate. [13]
- Montana ranked 50th (68.4%) compared to the average nationwide 83.1% of employees working in private businesses offering insurance. [14]
- DPHHS estimates that 10,000 children of low-income working parents in Montana will have no health insurance coverage or health plan even when CHIP is fully implemented.
- Forty-nine of 56 counties in Montana have primary care shortage areas. [15]

## WHAT MONTANA HAS ACCOMPLISHED

- 27 NHSC providers were "matched" to Health Professional Shortage Areas in Montana.
- CHIP was implemented as a pilot project in January 1999, and expanded to serve 9,725 children in October 1999.
- CHIP, Mental Health Service Plan, Caring Program, and Special Health Services revised their enrollment forms to one form currently used by all programs.
- CHIP discontinued the annual enrollment fee in June 2000 and made other changes that help working parents and families qualify for CHIP. Children, screened for Medicaid, now are able to have their eligibility for CHIP determined with one visit to the local Public Assistance Office.
- Local advocacy organizations through a contract with HMHB's "Covering Kids" project encourages the use of CHIP and Medicaid services in 14 communities.
- A successful statewide media campaign in 2000 resulted in 2 -- 2 ½ times the number of daily applications for children to be enrolled in Medicaid and CHIP.
- At least 3 statewide efforts have developed strategies and recommended policy changes to improve access to health care: State Coverage Initiative (SCI) Program White Paper– *Strategies for Improving Access to Health Care Coverage*, the Dental Access Summit and Coalition, and the Montana Child Health Care Needs Workshop.
- The NHSC SEARCH Program arranged preceptorships for about 60 family practice physician residents and medical, nurse practitioner, and physician assistant students to learn about health care in rural and underserved Montana settings.
- 43 counties recently updated applications for federal Health Professional Shortage Area (HPSA) and Medically Underserved Area/Population (MUA/P) designations. These designations help qualify areas for federal programs to improve access to health care, including NHSC, Medicare Incentive Payments, rural health clinics, federally qualified health clinics, J-1 visa waiver program, and others.
- In SFY 2001, DPHHS submitted an application to the Health Resources & Services Administration (HRSA) for a state planning grant for access to affordable health insurance benefits.

## WHAT STILL NEEDS TO BE DONE

- Improve access to public and private health care services, especially for at-risk populations and geographical areas lacking adequate coverage.
- Increase reimbursement for Medicaid providers to improve access.
- Assure that persons eligible for publicly financed health care services [such as Early Periodic, Screening, Diagnosis and Treatment (EPSDT) program and the Temporary Assistance for Needy Families (TANF)] are aware of their eligibility.
- Increase the income level eligibility for the CHIP program to 185% of the Federal Poverty Level.
- Work towards an adequate health workforce by 1) collecting more comprehensive workforce data, 2) enhancing incentive programs, and 3) strengthening recruitment and retention efforts.
- Continue to identify new or continued areas with health professional shortages, access barriers, or health disparities, so that resources can be most effectively utilized to increase access.

**For more information, contact**

**HEALTH SYSTEMS BUREAU**

**Primary Care Office**
**406/444-4748**

**MEDICAID & CHIP SERVICES BUREAU**

**Children's Health Insurance Plan**
**406/444-6971**

**Managed Care Section**
**406/444-4144**

# CANCER PREVENTION

## GOAL AND OBJECTIVES

**Promote prevention and early detection of cancer.**

- By the year 2010, reduce Montana's overall cancer death rate to the national target of 158.7 cancer deaths per 100,000 population. (Baseline: 168.3 cancer deaths per 100,000, 1993-1997.)
- By 2003, increase the number of eligible women screened annually through the Montana Breast and Cervical Health Program (BCHP) to 3,000 from within the target population of women ages 50 through 64, who are underinsured, uninsured, and income-eligible. (Baseline: 1,500 women screened in 1999.)
- By 2003, create an integrated and coordinated cancer prevention and control initiative with DPHHS programs, and community and state partners.
- By 2004, identify all available data sources and begin to describe the burden of cancer to the state of Montana.
- Ongoing, maintain outreach, recruitment, and screening activities for Native American women living on or near Montana's reservations.

**The four most common types of cancers among Montana residents are prostate, breast, lung and colorectal.**

## WHY IT'S IMPORTANT

- Montana citizens suffer significantly from the effects of cancer. Cancer is the second leading cause of death in the state. Annually, about 1,700 Montana citizens die from cancer.
- The National Cancer Institute estimates that up to 50% of cancer deaths could be avoided through the widespread use of proven techniques for prevention, early detection and state-of-the-art treatment.
- Breast cancer is the most common cancer among women in Montana.
- Annual breast cancer screening, which consists of a clinical breast exam and mammogram, and regular cervical cancer screening, which consists of a Pap test and a pelvic exam, can significantly reduce the morbidity and mortality of these diseases.

## WHAT MONTANA HAS ACCOMPLISHED

- *Cancer In Montana, 1993-1997* was published by DPHHS in August 2000. This publication of the Montana Central Tumor Registry and Chronic Disease Prevention and Health Promotion Section, provides state and county-specific cancer incidence data, state cancer mortality rates and information on cancer risks and associated factors.
- On September 30, 1999, the MBCHP added 7 new administrative sites to the program, completing the goal to provide outreach, recruitment, and screening services to all 56 Montana counties.
- As of July 1, 2000, the MBCHP had screened 2,500 women statewide for breast and cervical cancer.
- Memoranda of Understanding were established with the Billings Area Indian Health Service and two tribal health facilities in April 2000 to provide screening services to Native Americans living on or near Montana's seven Indian reservations.

## WHAT STILL NEEDS TO BE DONE

Outreach and recruitment activities must focus on the following "hard-to-reach" populations:

- Women who experience geographic barriers to screening, particularly those living in the more rural areas of Montana.
- Women who have never or rarely been screened for cervical cancer.
- Native American women living on or near Montana's reservations.

**For more information, contact:**

**HEALTH SYSTEMS BUREAU**

**Chronic Disease Prevention and Health Promotion Section**

**406/ 444-9020**

# CARDIOVASCULAR HEALTH

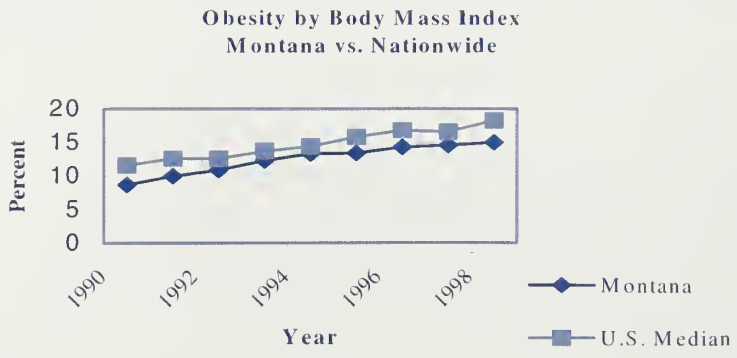
## GOAL AND OBJECTIVES

**Reduce illness and death from cardiovascular disease.**

- To increase to 95% the proportion of people with high blood pressure who are taking action to help control their blood pressure by December 31, 2003 (Baseline: 91 % in 1999).
- To increase to at least 70% the proportion of adults who have had their blood cholesterol checked within the preceding five years by December 31, 2003 (Baseline: 64 % in 1999).
- To develop a baseline measure of the proportion of middle and junior high schools that require daily physical education for all students by December 31, 2003.
- To increase to 28% the proportion of adults who achieve the 5 A Day guidelines of eating at least five servings of fruit and vegetables a day by December 31, 2003 (Baseline: Less than 25 % in 1998).

## WHY IT'S IMPORTANT

- Americans are living longer, but chronic disease has surpassed infectious disease as the leading cause of mortality in the nation.
- Cardiovascular disease is the leading cause of death in Montana. Heart disease and stroke accounted for 32% of all deaths in Montana in 1998.[16]
- Many of these deaths are due to behaviors that are modifiable—including physical inactivity, poor eating habits and tobacco use.
- From 1990-1998, the share of adult Montanans who reported no leisure time physical activity increased from 18 to 25%.[17]
- For the combined years 1997-1998, 52% of all Montanans were classified as either overweight or obese.[18]
- Fewer than 25% of adult Montanans reported eating at least five servings of fruit and vegetables a day.[19]
- In 1999, 24% of high school students smoked, and one of every three (33%) high school boys
- Used spit tobacco.[20]
- A person who is overweight or obese is at greater risk for hypertension, high cholesterol, type 2 diabetes, heart attack, and stroke.



## WHAT MONTANA HAS ACCOMPLISHED

- DPHHS formed the Montana Cardiovascular Disease Prevention Task Force and held the first quarterly meeting in July 1999.
- DPHHS published the *Montana Cardiovascular Disease Prevention and Control Plan 2000* in June 2000.
- DPHHS received a CVD core capacity grant from the Centers for Disease Control and Prevention.
- During 1999, DPHHS conducted several baseline assessment surveys targeting Montana physicians, consumers, and elementary school teachers and students. Results of these surveys were used in developing the *Montana Cardiovascular Disease Prevention and Control Plan 2000.*
- DPHHS worked with Eat Right Montana, a statewide nutrition and physical activity coalition, to:
  - Award 20 mini-grants to organizations to promote eating five servings of fruit and vegetables a day;
  - Pilot the "Kids' Sports and Fitness Fest" with elementary students to promote lifelong, non-competitive physical activity;
  - Sponsor a National Nutrition Month poster contest for elementary children; and
  - Develop a "Healthy Families 2000" statewide media campaign encouraging healthy behaviors in Montana families.
- In conjunction with The Fitness & Community Health Education Center at Kalispell Regional Hospital (The Summit) and the Office of Public Instruction, DPHHS developed and disseminated the "Reach for Health" curriculum to all elementary schools in Montana. This curriculum for 2nd and 5th grade teachers includes lesson plans and ideas to integrate nutrition, physical activity, and wellness with other subject areas.

## WHAT STILL NEEDS TO BE DONE

- Continue to seek sustainable funding to implement strategies in the *Montana CVD Prevention and Control Plan 2000.*
- Implement year 1 and year 2 priority strategies in the *Montana Cardiovascular Disease Prevention and Control Plan 2000.*

**For more information, contact**

**HEALTH SYSTEMS BUREAU**

**Chronic Disease Prevention and Health Promotion Section**

**406/444-9020**

# CHILD & ADOLESCENT HEALTH

## GOAL AND OBJECTIVES

**Ensure that Montana's children have the opportunity to grow up healthy and strong.**

- To increase to 70% to the number of newborns screened for hearing impairment by 2005. (Baseline: 57.4% FY 1999).
- To establish a baseline to determine hospitalizations for asthma in children under age 5 years.
- To identify children with adverse birth outcomes to create a baseline of Montana's incidence rate of identified birth defects by 2005. These data will improve existing services offered under the Children's Special Health Services Program and identify additional areas of unmet needs.
- To increase the percentage of infants who are breastfed at birth to 75% (Baseline: 73% FY 1999) and those who are breastfed for a duration that exceeds six months to 45% by December 31, 2005. (Baseline: 36% for FY 1999.)
- To improve the methods for identifying children at risk of lead poisoning and screen all children in high-risk groups by December 31, 2005.
- To promote the best nutrition for children by increasing participation in WIC to 75% of the estimated individuals eligible for the service by December 31, 2005 (Baseline: 69% for FY 1999).
- To provide comprehensive services to prevent/ or reduce the number of births of infants affected by Fetal Alcohol Syndrome/ Fetal Alcohol Effect by 2005.

*"Let us plant our children like trees by streams of water so that they will yield full fruit in their season."*
Marian Wright Edelman

"The measure of a society is how it cares for its most vulnerable citizens."

***Childhood is a unique developmental stage in life, which shapes adult health.***

## WHY IT'S IMPORTANT

- Early identification and management of hearing impairment, beginning in infancy, assures timely development of speech and oral language skills.
- Fetal Alcohol Syndrome/ Fetal Alcohol Effect is recognized as the leading cause of mental retardation and neurological dysfunction, yet it is 100 % preventable.

- Asthma is one of the most common chronic diseases of childhood, with children under 5 years old experiencing the highest increase in incidence of disease.
- Good nutrition, a positive self-image, and a safe environment enable a child to learn, to be a productive, contributing member of society, and to enjoy life to the fullest.

## WHAT MONTANA HAS ACCOMPLISHED

- Screened 57.4% of newborns in the state of Montana for hearing impairment prior to their leaving the hospital (1999 survey).
- Mobilized a multidisciplinary statewide task force to standardize the hearing screening process.
- Received funding from the Centers for Disease Control and Prevention to develop a database that helps to identify children with targeted birth anomalies.
- Created a statewide folic acid education partnership with the March of Dimes to educate providers and the public about the importance of preconceptual folic acid which has been shown to decrease the incidence of birth defects.
- Identified asthma as a health concern in daycare settings, Head Start centers and schools through a survey distributed by the Maternal Child Health Bureau.
- Established Lead Poisoning Prevention Coordinators in 10 sites across Montana. Montanans exposed to lead in Idaho's Silver Valley in the 1970's are being identified.
- Expanded, through $11,000 in private funds, the Farmers' Market Nutrition programs to Missoula, Flathead, Ravalli, Gallatin, Yellowstone, and Custer counties. This project provided WIC clients with coupons to purchase locally grown fresh fruits and vegetables at local markets.
- Begun to address FAS/FAE in the region, as one of four states in a Consortium funded by the Centers for Substance Abuse Prevention (CSAP).

## WHAT STILL NEEDS TO BE DONE

- Ensure that all Montana hospitals which provide delivery services have hearing screening equipment and staff trained in its use.
- Define the incidence rates for targeted birth defects in Montana.
- Establish ongoing financial support for Montana Birth Defects Monitoring System.
- Expand asthma outreach and education statewide.
- Review childhood lead screening criteria to ensure effective targeting of screening efforts to children who are at high risk for lead poisoning.
- Establish a reliable funding mechanism to obtain federal matching funds to establish a statewide Farmers Market Nutrition Program.
- Increase and systematize FAS/FAE data collection.
- Identify women at high risk for pregnancies that result in the birth of children with FAS/FAE.
- Develop and implement service capacity to individuals affected by FAS/FAE.
- Explore mechanisms to measure efficacy of parenting support and education programs.

**For more information, contact**

**FAMILY AND COMMUNITY HEALTH BUREAU**

**406/444-4103**

**Child, Adolescent and Community Health Section**
**406/444-2794**

**Nutrition Section (WIC)**
**406/444-4747**

**Special Health Services Section**
**406/444-3617**

# DIABETES PREVENTION & CONTROL

## GOAL AND OBJECTIVES

**Reduce the morbidity and mortality of diabetes and its complications among Montanans.**

The burden of diabetes is measured in terms of prevalence, health care utilization, complications, disability, death, and expenditures. The Montana Diabetes Project (MDP) is funded by the CDC and focuses its efforts in three primary areas: 1) surveillance, 2) health systems (improving the delivery of care for patients with diabetes), and 3) resource coordination.

- By June 30, 2001, establish and maintain a comprehensive statewide surveillance system for diabetes, health care utilization, and complications.
- By 2004, increase the number of persons with diabetes in Montana who receive an annual
  - comprehensive foot examination to 75 percent;
  - dilated retinal examination to 75 percent;
  - influenza immunization and at least a one-time pneumococcal immunization to 90 percent;
  - screening for urine microalbuminuria to 50 percent; and
  - HbA1C test to 50 percent.
- By 2004, demonstrate success in reducing health disparities for high-risk populations with respect to diabetes prevention and control.
- Ongoing, continue to maintain the MDP Advisory Coalition with key diabetes organizations and consumers in Montana and establish new partnerships with organizations for diabetes prevention and control.

*The burden associated with the severe complications of diabetes in Montana is high. Every year there are about 40 new cases of blindness, 150 lower extremity amputations, and 60 new cases of end-stage renal disease. Most of these complications could be prevented or delayed.*

## WHY IT'S IMPORTANT

- 54,000 Montanans have diabetes. An estimated 54,000 Montanans – 6.8% of the population – have diabetes. 4.1% have diagnosed diabetes and approximately 2.7% have undiagnosed diabetes.[21]
- Adult Native Americans have a higher rate of diabetes. In 1999, 12% of adult Montana Native Americans had diagnosed diabetes.
- Diabetes prevalence is increasing. Prevalence has increased from 1990 to 1998 in the U.S. (4.9% to 6.5%) as well as in Montana (2.8% to 4.1%).[22]
- Diabetes contributes to the death of at least 500 Montanans per year. As a leading cause of death, it ranks seventh for all Montanans, and fourth for Native Americans.
- Annually there are an estimated 7,504 hospitalizations related to diabetes, and 2,300 of these are cardiovascular-associated hospitalizations in Montana.
- In Montana, approximately $13,000 is spent each year in direct and indirect costs for each person with diagnosed diabetes.
- Nationally, more than 25% of the Medicare budget is spent on diabetes-related care.[23]

## WHAT MONTANA HAS ACCOMPLISHED

- The MDP was initially funding by the CDC in 1995. A statewide diabetes control plan was published in 1996 by a broad-based coalition of Montana providers, professionals, and persons with diabetes to direct the activities of the MDP. The MDP applied for competitive funding and was awarded a comprehensive grant in 1998.
- The MDP has established a statewide surveillance system to monitor trends in diabetes prevalence and health care utilization.

- The MDP in collaboration with the Billings Area Indian Health Service has established a surveillance system to monitor trends in diabetes among Native American youth.
- The MDP with the assistance of the Mountain-Pacific Quality Health Foundation has developed a diabetes care quality improvement program that is being implemented in primary care practices in Montana. Over 20 primary care practices and community health centers in Montana are participating. These practices provide care to over 2,300 persons with diabetes.

- The MDP has implemented a diabetes education program to increase the number of health care professionals and programs providing such education.
- The MDP is working collaboratively with the Billings Area Indian Health Service and the DPHHS Cardiovascular Health Program to establish diabetes school-based screening programs for Native American communities.

- The MDP co-sponsors an annual statewide patient/professional diabetes education conference.
- The MDP maintains an active diabetes advisory coalition that meets quarterly.

## WHAT STILL NEEDS TO BE DONE

- Expand the number of primary care offices in Montana participating in the diabetes quality improvement program.
- Expand intervention programs targeted toward Montanans with diabetes to reduce the associated complications.

- Collaborate with Billings Area Indian Health Service to implement the diabetes school-based screening program for Native American children and adolescents.
- Increase awareness of the seriousness of diabetes and importance of screening for diabetes among Montanans at risk.

- Develop a statewide surveillance system to monitor the prevalence and incidence of diabetes among Montana youth.

**For more information, contact**

**HEALTH SYSTEMS BUREAU**

**Chronic Disease Prevention and Health Promotion Section**

**406/444-9020**

# EMERGENCY MEDICAL SERVICES AND STATEWIDE TRAUMA SYSTEMS

## GOAL AND OBJECTIVES

**Assure prompt, effective emergency medical services and trauma care for Montana's citizens and visitors through development of a comprehensive, integrated, statewide Emergency Medical Services (EMS) System.**

- To increase the proportion of persons who have access to rapidly responding prehospital emergency medical services by assuring 60% of the emergency calls in rural areas receive emergency assistance on-scene in ten minutes or less.
- To develop, by July 2002, a comprehensive prehospital data collection system in which each EMS service collects a uniform data set and contributes information to a state EMS data set.

- To implement guidelines for prehospital and hospital pediatric emergency care by July 1, 2002.
- To integrate a comprehensive emergency medical services education plan with Montana's higher education system by June 30, 2003.

- To establish a comprehensive program for recruiting and retaining emergency medical services providers, particularly in rural, volunteer services, by June 30, 2003.
- To establish a statewide trauma care system that maximizes survival and functional outcomes of trauma patients and helps to prevent injuries from occurring by July 1, 2003
- To establish a dedicated, statewide funding source to support state and local EMS education, training, and EMS and trauma system implementation by July 1, 2003.

Montana's EMS and trauma system serves as a "safety net" for the rest of the health care delivery system – particularly with the closure of rural hospitals.

## WHY IT'S IMPORTANT

- An excellent EMS system reduces deaths, decreases the seriousness of injuries, and lessens rehabilitation time. The scarcity of medical resources in rural areas, combined with long emergency transport distances, makes the availability of an excellent EMS and trauma system even more critical.

- Montana's EMS services are primarily autonomous local units staffed by 5,037 prehospital care providers. Many of these are volunteers with limited resources for initial and continuing education.

*Whenever an automobile crash, a heart attack, a poisoning, or any other unexpected medical emergency occurs, the EMS system must*

- *be promptly available*
- *provide excellent care*
- *perform consistently*

*under the most adverse conditions.*

- EMS services across the state are experiencing significant declines in participation. This threatens the stability of Montana's predominantly volunteer emergency medical services and trauma care system.
- A trauma care system, carefully integrated with the EMS system, can reduce preventable injury mortality by at least 20%. According to a study conducted in 1993, Montana's preventable injury mortality rate is 17%.
- Montana's EMS and trauma system serves as a "safety net" for the rest of the health care delivery system particularly with the closure of rural hospitals.

## WHAT MONTANA HAS ACCOMPLISHED

- Montana has an excellent EMT certification and testing system.
- Most Montana ambulance services are now staffed with at least EMT-Basic personnel.
- Computers have been placed in nearly every Montana ambulance service; a prehospital EMS data collection software contract has been awarded and software is undergoing testing.
- A CDC trauma system development grant helped to begin establishing a statewide trauma system, but this grant will expire on September 30, 2001, with no funding to continue trauma system development.
- Trauma System Administrative Rules including facility designation and facility standards have been drafted and forwarded for rule making.
- The State Trauma Care Committee was appointed and became operational in 1995
- The Montana Trauma System Plan and enabling legislation was adopted in 1994.
- Three Regional Trauma Advisory Committees (RTACs) became active in 1994.

## WHAT STILL NEEDS TO BE DONE

- Align the trauma care plan and EMS system objectives with financial incentives from Medicaid, Medicare, and other third-party payers.
- Assure that emergency services have proper medical direction and oversight.
- Assure the continued statewide availability of excellent poison control services.
- Assure emergency medical services dispatchers have excellent training through a statewide emergency medical dispatch-training program.

**For more information, contact**

**HEALTH SYSTEMS BUREAU**

**EMS & Injury Prevention Section**

**406/ 444-4126**

# ENVIRONMENTAL EPIDEMIOLOGY

## GOAL AND OBJECTIVES

**Protect Montanans from harmful effects of toxic substances in our environment.**

- To recruit a doctoral-level epidemiologist who has specialized training and experience in non-infectious disease epidemiology by January 1, 2001.
- To establish within DPHHS by June 30, 2001, a coordinated and comprehensive Environmental Epidemiology Program that includes a broad-scale surveillance and monitoring system which can discern and measure known environmental hazards.
- To respond to all reports of clusters of adverse health events utilizing standardized protocols and investigative methods throughout the 2002-2003 biennium.

*Environmental factors play a paramount role in health and disease.*

## WHY IT'S IMPORTANT

- Montana is home to our nation's largest Superfund site complex. There are 225 Superfund sites in Montana; 13 are on the National Priority List.
- Toxic substance releases have occurred at sites where mining, smelting, wood-treating, railroad fueling & degreasing, petroleum refining, land filling, and chemical manufacturing/storage activities have been conducted. Contamination of air, surface water, ground water, sediments, and soils at these sites may pose serious human health problems.
- The asbestos poisonings in Libby have caused the number of reports of environmental health problems in Montana to burgeon.
- Responding to citizen reports of environmental health problems in Montana is a fundamental duty of state government. Each reported problem must be taken seriously and must receive the attention that our residents expect and deserve.

## WHAT MONTANA HAS ACCOMPLISHED

- A formal Memorandum of Understanding between DPHHS and DEQ has been established to ensure health and environmental issues remain integrated following state agency reorganization in 1995.
- Federal funding has been procured to enhance the usefulness of the Montana Central Tumor Registry.
- DPHHS has published a report on the impact of cancer, titled *Cancer in Montana, 1993-1997.*
- DPHHS investigated 17 citizen reports of potential environmental impacts on human health during SFY 2000.

## WHAT STILL NEEDS TO BE DONE

- Acquire the capacity to respond to reports of clusters of adverse health events in a manner that Montanans expect and deserve.
- Upgrade the scientific staff of DPHHS to include a health professional with specialized education, training, and experience in non-infectious disease.
- Develop a coordinated and comprehensive Environmental Epidemiology Program.

**For more information, contact**

**COMMUNICABLE DISEASE CONTROL & PREVENTION BUREAU**

**Communicable Disease & Epidemiology Section**

**406/444-0273**

# FOOD SAFETY

## GOAL AND OBJECTIVES

**Increase the safety of food served to Montana's citizens and visitors.**

- To update the existing foodservice regulations to substantively reflect the content of the 1999 Food and Drug Administration (FDA) Model Food Code by January 1, 2001.
- To increase by 10% the food safety training opportunities for inspection staff at the state and local level and for foodservice operators statewide by July 1, 2001
- To standardize local and state food establishment inspection and plan review services by January 1, 2002.
- To revise the foodservice licensing fee system by October 31, 2001 in order to provide more adequate support for local safety programs and to more equitably reflect the level of service provided to different types of establishments.

*According to national data, about one in 65 Montanans will be sickened by food-borne illness each year.*

## WHY IT'S IMPORTANT

- Most food-borne illnesses can be prevented.
- When food service establishments are involved, one source of illness or bacteria can infect large numbers of people.
- While most of those affected by food-borne illnesses will be healthy again after a day or two of nausea/diarrhea, some will need hospitalization.
- The cost of food-borne illness is tremendous, as scarce public resources must cover lost wages, health care, and investigative costs.
- The majority of food-borne illnesses are caused by food kept at inappropriate temperatures, illness of food handlers, and unsanitary practices.

## WHAT MONTANA HAS ACCOMPLISHED

- Established a Food Code Task Force to review the 1999 FDA Model Food Code, predominately representing the foodservice industries in Montana. The Task Force has reached consensus on the updated food service regulations. Draft regulations have entered into the formal rule adoption process.

- Offered the nationally recognized "SERVSAFE" food safety training program in conjunction with the MSU Extension Service and industry representatives. More than 70 county sanitarians, Extension Educators and industry trainers have been trained and certified as trainers to provide the SERVSAFE course to all levels of the foodservice industry.

- Developed, through an interdepartmental training team, a coordinated Hazard Analysis Critical Control Point (HACCP) training program for the food manufacturing industry. The team has completed the training of small meat processors throughout the state and is designing a HACCP training program for retail food operators.

- Provided, on an ongoing basis, training for county sanitarians at quarterly regional meetings and at the state-wide training conferences that are offered to all local sanitarians twice each year.

## WHAT STILL NEEDS TO BE DONE

- Complete the adoption of the foodservice regulations based on the recommendations of the Food Code Task Force.

- Revise the statutes for Food Establishments (MCA 50-50) to provide a system for assessing variable license fees based on 1) the potential risk each type of food establishment may pose to the health of the public and 2) the level of food safety inspection and education services required by different establishment types.

- Increase FTE authority to full time for the section's Compliance Investigator position. This will provide additional support for training of food service operators and local inspectors regarding the updated food service regulations.

**For more information, contact**

**COMMUNICABLE DISEASE CONTROL AND PREVENTION BUREAU**

**Food and Consumer Safety Section**

**406/ 444-2408**

# HIV/AIDS TREATMENT

## GOAL AND OBJECTIVES

**Maintain the low incidence of HIV infection in Montana and make appropriate treatment options available to those who are infected.**

- To continue present level of uninterrupted service to the 100+ clients already in the Ryan White Title II program throughout the 2002 - 2003 biennium.
- To stabilize funding and maintain qualification income levels so individuals may return to employment without jeopardizing funding for very high-cost medications.
- To provide service for the anticipated 20-30 new clients who will apply for this program annually during SFY 2002 and 2003.

***New HIV drugs may delay the onset of AIDS indefinitely. They cost about $10,000 per year per patient.***

Standard hospitalization for treatment of opportunistic infections because of AIDS can cost more than $1,500 per day per patient.

## WHY IT'S IMPORTANT

- Montana has approximately 500 citizens living with HIV or an AIDS diagnosis.
- With the help of anti-retroviral medications, most HIV-infected people can delay the onset of AIDS and maintain active and productive lives for many years.
- Anti-retroviral medications can retail at $800 - $1200 or more per month.
- Ensuring everyone access to these life-prolonging treatments is the mission of the Ryan White Title II AIDS Drug Assistance Program (ADAP), which is a federal grant administered through DPHHS.
- ADAP is literally a lifeline for persons whose incomes are below 300% of the federal poverty level, and are ineligible for Medicaid.
- As of 10/1/00, medication needs of 5 clients are not being met.
- As of 10/1/00, the waiting period to be enrolled is 2 months.

## WHAT MONTANA HAS ACCOMPLISHED

- DPHHS supports 14 sites for HIV testing and prevention activities.
- The STD/HIV Section operates a 24-hour toll-free information line where Montanans can receive information about HIV and other STDs , as well as testing and treatment options.
- DPHHS' STD/HIV Section funds seven consortia sites where HIV positive clients receive case management services and assistance with locating necessary healthcare, housing, and nutritional support.
- As a result of increased funding at the federal level, and cost saving efforts accomplished in the administration of Montana's Ryan White Title II grant, over 100 HIV infected persons, most of them struggling to support themselves with incomes less than 200% of the federal poverty level, now have an equal chance at life.
- Through a health insurance continuation program, an AIDS drug assistance program, and through conscientious case management, needy Montanans with HIV/AIDS are maintaining more productive and more normal lives.
- DPHHS supports education for healthcare providers regarding appropriate treatment of HIV disease.
- DPHHS provides technical assistance and training to private and public health professionals to improve HIV counseling and partner notification services.

## WHAT STILL NEEDS TO BE DONE

- Identify those persons infected with HIV who have no other resources for treatment support.
- Refer those persons to appropriate medical care and support their need for drug treatment to the extent necessary, maximizing their continued ability to be self-supporting, tax-paying citizens.
- Identify what other basic support HIV infected individuals need to stabilize them and reduce the opportunity for transmission to others. Housing and basic nutritional support are critical to the success of the new treatment programs.
- Educate young people about the risks of HIV and about prevention strategies.
- Build better understanding of HIV and more skills in delaying sexual activity and/or preventing HIV transmission.

**For more information, contact**

**COMMUNICABLE DISEASE CONTROL AND PREVENTION BUREAU**

**STD/HIV Section**

**406/ 444-3565**

# IMMUNIZATIONS

## GOAL AND OBJECTIVES

**Assure that immunization rates increase for all Montanans.**

- To have a minimum of 90% of children in Montana appropriately immunized by age 2 years, as measured by assessing immunization rates against the following standard, 4 DTaP, 3 Hib, 3 Polio, 1 MMR, and 3 Hep B doses by age 35 months.
- To establish, by December 31, 2002 a baseline immunization rate for adolescents, aged 11 – 12 years, for the following vaccines: complete Hep B series, 2 MMR, and a current Td booster.
- To assure, by December 31, 2002 that at least 80% of adults age 65 years and older, living in *institutional* settings, and at least 60% of adults age 65 years and older, living in *non-institutional* settings, are immunized annually with influenza vaccine, and have a recorded dose of pneumococcal vaccine.
- To assure, by December 31, 2002 that at least 80% of primary health care providers who see adults age 18 – 64 years, at risk for viral hepatitis disease, will be reminded to offer hepatitis vaccine when seeing clients in public or private health care settings. Adults at increased risk are: injection drug users, long-term prison inmates, sexually active adults with more than one sex partner in the prior 6 months, persons with a recently acquired STD, and household or sexual contacts of people chronically infected with hepatitis B virus.

***Vaccines are one of the greatest public health achievements of the last century.***

## WHY IT'S IMPORTANT

- A high immunization rate makes it difficult to sustain an outbreak of disease because there are fewer susceptible members of the community.
- Tetanus immunity, however, can not be insured by "herd immunity." All persons must be vaccinated with tetanus toxoid (Td) to achieve the goal of zero cases in Montana.
- A Hepatitis B outbreak with deaths in north central Montana during 1998-1999 focused on the need for prevention of hepatitis B and improved education for adolescents regarding the risk factors and transmission of this liver disease. This is critical before these young adults leave school systems, become more difficult to reach, and engage in increasingly at risk behaviors.
- Influenza can be prevented with a safe, effective vaccine, which is fully paid for by Medicare Part B for Medicare-eligible clients.

| | |
|---|---|
| *Immunization remains a dynamic system, with new vaccines regularly becoming available.* | • Influenza and pneumonia related deaths together are the sixth leading cause of death in the U.S., and the fifth leading cause of death among older adults. During most influenza seasons, 10% - 20% of the population is infected with influenza with an annual estimated cost to society of up to $12 billion during severe epidemics.<br><br>• Influenza can worsen chronic heart disease, lung disease, and diabetes, and can lead to bacterial or viral pneumonia. It can also lead to hospitalization and death. Each year there is an average of 140,000 influenza-related hospitalizations in the U.S. This number climbs to more than 300,000 during severe seasons. Pneumococcal pneumonia accounts for up to 25% to 35% of all adult pneumonias leading to hospitalization, and is the most common cause of pneumonia. Vaccines are among the safest medicines available. |

## WHAT MONTANA HAS ACCOMPLISHED

- 90.4% of the children between the ages of 24 – 35 months are up to date on the age appropriate vaccine doses for 4 DTP, 3 Polio, 3 Hib, 1 MMR, according to the 1999 assessment of the immunization rates for children seen in public and private vaccine provider sites in Montana. [24]
- 87% of the residents of licensed nursing homes in Montana had received the influenza vaccine in the 12 months preceding a March 2000 survey. Only 70% of the residents had a recorded dose of pneumococcal vaccine. [25]
- 72.9% of persons 65 years of age and older had received the influenza vaccine in the 12 months prior to participating in the BRFSS survey in 1998. Only 55.9% of the respondents of this age group were aware of having received the pneumococcal vaccine sometime in the past.

## WHAT STILL NEEDS TO BE DONE

- Increase the focus on adolescent immunization over the next four years.
- Develop a plan to establish a baseline immunization rate for adolescents, aged 11-12 years, for the following vaccines: Hep B complete series, 2 MMR, and a Td booster.
- Explore funding sources to purchase vaccine for adults 19 – 64 years of age who are at risk for vaccine preventable disease(s), are uninsured and have no other funding mechanism.

**For more information, contact**

**COMMUNICABLE DISEASE CONTROL & PREVENTION BUREAU**

**Immunization Section**
**406/444-5580**

# INFORMATION ACCESS & SECURITY

## GOAL AND OBJECTIVES

**Integrate public health data systems and protect confidential client information in accordance with federal and state statutes and regulations.**

- To implement a comprehensive, secure, Public Health Data System (PHDS) for all local health departments by June 30, 2001. The PHDS will include an immunization registry electronically linked to Montana's birth records and will share immunization data with the Indian Health Service.
- To implement a secure Sharing of Public Health Information (SOPHI) system to link the PHDS with the other health data systems used in Montana's cities and counties by June 30, 2001. The SOPHI will, with client authorization, facilitate client referrals and intake across local public health programs and across the state.
- To develop and implement an Integrated Data for Evaluation and Analysis (IDEA) Information Center by February 28, 2002. De-identified information will be extracted from the PHDS and linked with extracts from other DPHHS health data systems (e.g., Medicaid) to perform complex analyses of the effectiveness of public health programs on client health outcomes.
- To complete full-scale training, support, and evaluation of the data integration system project and develop links with private health care providers to electronically add to the PHDS information about the immunizations they provide to Montana citizens.
- To ensure compliance with state laws and policies and with the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 guidelines for protecting client-identifiable public health data by January 31, 2003.

***City, county, and state health professionals currently must use more than 15 separate data systems for information about services and clients of Montana's public health programs and Medicaid.***

## WHY IT'S IMPORTANT

An integrated data system will provide local public health providers with:

- Efficient client intake across multiple programs. Separate local data systems often require local staff to enter duplicate data and maintain separate records on the same clients.
- Improved coordination of services among local service area programs.
- Easier production of required reports.
- Comprehensive data for evaluating and planning local public health services. Without integration of data, local health professionals have no direct method of evaluating the overall effect of multiple programs or of coordinating program activities for clients and families.
- Enhanced control and protection of client-identifiable information to ensure that client confidentiality is maintained.

## WHAT MONTANA HAS ACCOMPLISHED

- Beginning in 1996, the IDEA Project team completed an analysis of system and user needs and developed a project plan. The project was designed in phases to ensure the most effective use of existing resources and to provide the maximum immediate benefit to the counties.
- In 1997 and again in 1999, the Montana State Legislature authorized the use of federal funds to implement the IDEA data integration project statewide.
- DPHHS applied for and received federal funding, including three national competition awards, to implement the PHDS and SOPHI.
- Project activities have included:
  - formation of a Data Integration Advisory Council of stakeholders and a confidentiality subcommittee of that Council.
  - definition of local system needs through a system requirements analysis, a national search of public and private sector software that might be customized to meet system requirements, production of documents with prototype screens and descriptions of required functionality.
  - development of the PHDS and SOPHI in compliance with Montana statutes governing confidentiality of client health information.

## WHAT STILL NEEDS TO BE DONE

- Complete Phase I and II of the IDEA Project by installing PHDS and SOPHI statewide.
- Create and implement the IDEA Information Center and electronic linkage of private providers of immunizations to the PHDS.
- Share Montana's data integration strategies and solutions on a regional and national basis.
- Implement the HIPAA regulations within 26 months of their final publication.

**For more information, contact**

**FINANCIAL, OPERATIONS AND SUPPORT SERVICES BUREAU**

**IDEA Project**
**406/ 444-3634**

# INJURY PREVENTION

## GOAL AND OBJECTIVES

**Bring about long-term reductions in unintentional deaths and injuries.**

- To reduce deaths caused by motor vehicle crashes to 24 per 100,000 by 2003 and to 20.0 per 100,000 by 2010. (HP 2010 target rate: 9.0 deaths per 100,000; Montana death rate from motor vehicle crashes, 1997: 25.5/100,000).
- To increase Montana's seat belt use rate from 75% in 1999 to 90% by 2005 and to 92% by 2010.
- To increase child safety seat use from 92% in 1998 (national data) to 100% by 2010.
- To reduce child occupant (ages 0-4) fatalities from 3-6 per year (1995-97) by 25% to 1-2 per year by December 2005.
- To reduce Montana's death rate from falls from 9.6 to 9.1 per 100,000 by 2003 and to 7.0 per 100,000 by 2010 (HP 2010 target rate: 2.3 deaths per 100,000; Montana death rate from falls in 1997: 9.6/100,000).
- To develop strategies to reduce hip fractures among the elderly in Montana to the HP target rate of 491/100,000 for women over 65 and 450.5/100,000 for men over 65; Montana currently has incomplete data on hip fractures.
- To reduce drowning related deaths in Montana from 3.6/100,000 to 0.9 drownings per 100,000 by 2010. (HP 2010 target rate: 0.9 drownings per 100,000)
- To develop a statewide emergency department surveillance system that collects data on external causes of injury by 2005.
- To establish a permanently funded, comprehensive injury prevention program within the DPHHS by 2003.

***The leading causes of injuries in Montana are motor vehicle crashes, falls, firearms-related injuries, and drowning.***

## WHY IT'S IMPORTANT

- In the past decade, more than 6, 000 people have died from unintended injuries in Montana.
- Montana's unintentional injury death rate is higher than the US rate and the HP 2010 target:
  - Montana: 1997 --50.4/100,000
  - U.S. unintentional injury death rate of 34.8/100,000; HP 2010 target rate of 20.8/100,000.
- A *portion* of the data[26] representing serious trauma and hospitalizations shows that from 1993 - 1998, 2,378 Montanans were hospitalized from fall injuries. In the same time period, 1,639 Montanans were hospitalized with firearm injuries.

- Motor vehicle crashes are the leading cause of injury and fatality in Montana from ages 1-44. 47.9% of fatal crashes in 1999 were alcohol-related.
- In Montana, the probability of dying in a crash while properly using a seat belt is 1/1000. It is 15/1000 if unbelted. In other words, an unbelted driver is 15 times more likely to die.

## WHAT MONTANA HAS ACCOMPLISHED

- DPHHS established an Injury Prevention and Control Program and hired a statewide Injury Prevention Coordinator.
- The Injury Prevention and Control program is funded by a grant from the Emergency Medical Services for Children program and is being implemented as part of the State Trauma Care System.
- A statewide injury prevention and control plan has been completed.
- DPHHS has coordinated Open Water Drowning, Child Occupant Protection Program, Bicycle Safety & Helmet Use, Comprehensive Pediatric Injury Prevention (Risk Watch), Senior Fall Injury Prevention, and Suicide Prevention activities in 2000.
- DPHHS has been coordinating local injury prevention awareness and activities through the Regional Trauma Advisory Committees.

## WHAT STILL NEEDS TO BE DONE

- Permanent funding will enable The Injury Prevention and Control Program to continue to be an integral component of the Emergency Medical Services (EMS) and Trauma System.
- Available data should be used to target areas of injury prevention, including evaluation of the effectiveness of injury prevention efforts.
- DPHHS will encourage the active involvement of emergency medical services, health care providers, and public safety personnel in Injury Prevention and Safety Awareness through the provision of training, technical assistance and evaluation.
- DPHHS Injury Prevention and Control Program will work with Regional Trauma Advisory Committees and EMS providers to prevent injury in Montana including education, suggested legislation and changed safety designs.

**For more information, contact**

**HEALTH SYSTEMS BUREAU**

**EMS & Injury Prevention Section**

**406/ 444-4126**

# ORAL HEALTH

## GOAL AND OBJECTIVES

**Prevent and control oral and craniofacial diseases, conditions, and injuries and improve access to oral health-related services.**

- To maintain the existing Medicaid dentist participation rate and increase access by 10% for new Medicaid recipients by 2005 (Baseline: 412 dentists in FY 2000).
- To increase the number of dental HPSA designations in Montana from 3 (FY 2000) to 30 by 2003.
- To increase by 20, the number of schools participating in the School Based Fluoride Mouthrinse program by 2005. (Baseline: 257 schools in FY 2000).
- To provide training that would promote an oral health surveillance system in 30 communities by 2003.
- To conduct educational sessions on community water fluoridation in 12 communities by 2003.

***"Oral health is essential to general health and well-being."***

*Surgeon General's Report on Oral Health.*

## WHY IT'S IMPORTANT

- Access to dental services is at crisis levels for the poor, uninsured and underinsured who tend to suffer from disproportionate levels of oral health problems.
- Periodontal disease affects 75% of adults and has been linked to numerous life-threatening illnesses, including heart and lung diseases, stroke, diabetes, anemia, hemophilia, oral cancer, kidney disease, and low-birthweight and premature births.
- Dental decay is a major health concern. Over 52 million hours of school attendance is lost due to oral health problems each year.
- Montana lacks college level programs for dentistry and dental hygiene adding to the current shortage of dental health professionals to meet current needs.
- 74% of Montanans do not have access to optimally fluoridated water supplies.
- Montana has one of the highest rates for smokeless tobacco use in the country.
- People with developmental disabilities, the elderly, and children with special health care needs are at high risk for oral health problems.
- More than 65% of all cases of child abuse involve trauma to the mouth, face or head.

## WHAT MONTANA HAS ACCOMPLISHED

- Increasing Medicaid provider rates is a top DPHHS priority.
- DPHHS removed administrative barriers in the Medicaid dental program, and expanded the definition of emergency dental services making services more available to families trying to work.
- DPHHS increased the CHIP dental benefit from $200 to $350 and simplified the dental provider enrollment process.

- The Montana Dental Access Coalition (MDAC) was initiated through a collaborative effort with federal agencies and DPHHS to address access to dental care issues in Montana. Four workgroups including: Data Collection, Finance and Policy Development, Public Education and Workforce Analysis developed strategies to improve oral health in Montana for consideration by the Legislative Interim Committee on Children Health and Families.
- A MDAC website was created to provide current information regarding MDAC activities and provide links to other oral health related sites.

- The Montana Primary Care Office and the Montana Dental Association submitted a survey to all 465 licensed dentists to collect important information on workforce trends and needs (8/2000).
- DPHHS participated in a site visit they requested from the Association of State and Territorial Dental Directors (ASTDD) to assess the program and provide recommendations for improvement (3/2000).
- DPHHS reallocated workloads for the State Dental Director and the Medicaid Dental Program Manager in order to allow 100% dedication to oral health issues.

## WHAT STILL NEEDS TO BE DONE

- Develop a strategic oral health plan for the state that emphasizes primary prevention through the expansion of sealant and fluoridation programs based on strategies developed from the Montana Dental Summit, *Healthy People 2010*, and the Surgeon General's Report on Oral Health.
- Work to strengthen the dental public health infrastructure within DPHHS.
- Continue to pursue partnerships with the Montana Dental Association (MDA) and other key community partners to identify oral health issues of mutual concern and develop a sense of shared ownership of possible solutions.
- Develop and implement a data collection plan for the state that incorporates water fluoridation status, Maternal and Child Health (MCH) performance measures, and other indicators of the National Oral Health Surveillance System. Assure that health status indicators are keyed to the oral health objectives of Healthy People 2010.
- Work with the Department of Environmental Quality (DEQ) to enable Montana to participate in the Centers for Disease Controls (CDC) national Water Fluoridation Reporting System (WFRS).

**For more information, contact**

**FAMILY AND COMMUNITY HEALTH BUREAU**

**Child, Adolescent and Community Health Section**

**406/ 444-0276**

# PUBLIC HEALTH IMPROVEMENT

## GOAL AND OBJECTIVES

**Develop a coordinated system of communities and agencies that works together to protect people from harmful conditions, promote healthy behaviors, and assure access to quality health care.**

- By April 2002, serve at least 85% of the public health personnel statewide through a public health training program that is 1) coordinated among system partners and 2) based on best practices, professional competencies, and performance standards.
- By December 2002, develop a working model (blueprint) for public health system integration and coordination.
- By August 2003, reach 50% of Montana's county public health and tribal health agencies through information technology that enhances system communications, employee productivity, and training.
- By December 2004, develop a public health performance management system, based on the core functions and essential services of public health, reflecting the diversity of Montana's communities.

*Only one percent of the nation's health expenditures are directed toward population-based public health programs.*

## WHY IT'S IMPORTANT

- The current public health system is fragmented. Threats to the public's health from natural disasters, emerging infections, chronic diseases, and environmental health are on the rise. To address these challenges, Montana needs a strong, coordinated public health system.
- Public health training is lacking. Regardless of professional, academic, or skill background, many public health workers lack formal or consistent public health training.
- Adequate technology is missing. Montana's vast rural areas necessitate that public health practitioners have access to information technology for distance learning, patient care delivery, and system communications. Currently, only seven counties in Montana have adequate technology to meet these needs.
- Performance measurement is lacking. Experts in quality improvement have long asserted that "what gets measured gets done." Currently, Montana does not have a comprehensive, systematic performance management system. Public health needs useful benchmarks, which target quality improvement; increased accountability for dollars invested; and increased credibility with internal and external partners.

## WHAT MONTANA HAS ACCOMPLISHED

- 1996 – The Montana Public Health Improvement Task Force published the *Montana Public Health Improvement Plan* identifying the current health status of Montanans, core public health functions, local and state agency roles and responsibilities, and recommendations for public health improvement.
- 1997 – DPHHS and four community coalitions received Robert Wood Johnson and W. K. Kellogg Foundation "Turning Point" grants to work on public health improvement efforts.
- 2000 – Montana completed a study of the public health workforce that outlined the training needs of public health professionals and provided specific recommendations for educating the workforce.
- 2000 – The Montana Public Health Improvement Task Force, along with other public health stakeholders, published *The Strategic Plan for Public Health System Improvement.* This Plan, with statewide input, describes a process for establishing a coordinated public health system.
- 2000 – DPHHS received a start-up grant from the Robert Wood Johnson Foundation to establish a public health training institute in Montana. The institute is viewed as a career-long learning center for public health employees and other members of the public health system.
- 2000 – Montana is one of seven states participating in a national collaborative on performance measurement and standards through the National Turning Point Initiative.

## WHAT STILL NEEDS TO BE DONE

- Maximize the availability of resources to support the Montana Public Health System in fulfilling its mission.
- Develop an accurate picture of the current resource allocation in the public health system and develop a dedicated source of ongoing state funding for the public health system.
- Establish and maintain a public health education and information process to increase awareness of the importance of public health.
- Develop and maintain a statewide public health workforce that is fairly compensated.

**For more information, contact**

**HEALTH SYSTEMS BUREAU**

**Turning Point Coordinator**

**406/444-4474**

# PUBLIC HEALTH LABORATORY SERVICES

## GOAL AND OBJECTIVES

**Reduce communicable disease in Montana through a surveillance system based upon public health laboratory disease diagnosis and assessment.**

- To maintain at 100% the proportion of local health departments and other public clinics with access to accurate, reliable, population-based, public health laboratory services during the 2002 – 2003 biennium.
- To maintain the state's capacity to provide rare and technically difficult laboratory procedures to test for conditions that affect the health of Montanans throughout the 2002 – 2003 biennium.
- To develop a long-range plan for remodeling and updating the laboratory physical plant to meet current recommendations in regard to biosafety level III capabilities by the end of FY 2001..
- To develop and implement a mechanism for providing pertinent laboratory operations information to health care providers throughout Montana.

*The Montana Public Health Laboratory is staffed 7 days per week and conducts an average of 2400 tests per week.*

***DPHHS will conduct at least 125,000 tests in SFY 2001.***

## WHY IT'S IMPORTANT

- The primary function of a public health laboratory is to provide support for public health programs.
- Unlike a private clinical laboratory, Montana's Public Health Laboratory is concerned with the health of the community as a whole, not just that of individual patients.
- DPHHS has a responsibility to protect the public from the spread of infectious diseases and conditions that affect their health.
- Early identification of disease conditions by the Public Health Laboratory assures appropriate treatment and limits or prevents the spread of disease.
- Identification of populations at increased risk of illnesses gives policy makers information for reducing the burden or spread of illness.

## WHAT MONTANA HAS ACCOMPLISHED

The DPHHS Public Health Laboratory:

- Performs analysis of 125,000 specimens per year. Examination of specimens identifies disease outbreaks by isolating and identifying causative agents.
- Tests for diseases of public health significance, such as tuberculosis, that are too rare and unusual to be identified by other laboratories.
- Tests over 12,000 specimens each year, offering low-cost, confidential testing for diseases, such as those transmitted sexually, which are prevalent in populations not likely to approach private health providers.
- Performs 45,000 tests each year to accomplish population surveillance testing such as newborn screening for metabolic disorders.
- Researches new and emerging pathogens, such as toxin-producing *E. coli*, in what is or may become an outbreak situation, as the need arises.
- Centralizes data for rapid transmission to epidemiologists, infectious disease specialists, and other health policy decision-makers in Montana and elsewhere.
- Provides reference services such as viral isolation and identification, including those of rare and unusual microorganisms that local laboratories cannot identify, for approximately 2,000 patient samples each year.

## WHAT STILL NEEDS TO BE DONE

The Public Health Laboratory must enlist support from all segments of the health care system to aid the recognition of its place in assuring the public's health and safety. The laboratory needs to:

- Remain on the cutting edge of laboratory technology to meet the growing need for preventative services and to maintain the ability to identify rare and emerging diseases.
- Evaluate new testing procedures with public health significance for possible addition to the current test menu.
- Maintain a laboratory fee schedule competitive with private industry while continuing to help local public health providers protect the health of their community at affordable costs.

**For more information, contact**

**LABORATORY SERVICES BUREAU**

**Public Health Laboratory Section**

**406/ 444-3444**

# SEXUALLY TRANSMITTED DISEASE PREVENTION

## GOAL AND OBJECTIVES

**Reduce the incidence of sexually transmitted diseases in Montana, particularly among the adolescent and young adult population.**

- To keep the rate of chlamydia at or below 174 per 100,000 persons in the Montana population through 2000 and reduce it to 140 per 100,000 population or less by January 1, 2005.
- To reduce the rate of chlamydia among Native Americans to 900 per 100,000 population by January 1, 2005.

*Note: The above rates have increased due to changes in laboratory test methods and associated increases in test sensitivity. Expansion of screening programs to populations with higher prevalence of disease has contributed to these perceived increases. As we identify and treat more infected persons, the rates will begin to fall.*

- To reduce the number of sexually active adolescents to 40% by January 1, 2005.
- To increase the percentage of sexually active youth that consistently use condoms from 60% to 65% and reduce the number infected with chlamydia to 400 by January 1, 2005.

*In 1999, 43% of Montana adolescents surveyed reported that they were sexually active; only 60% of those sexually active adolescents reported using condoms.*

***In 1999, approximately 1591 cases of chlamydia were reported in Montana; 653 (41%) of those cases occurred in 15-19 year olds.***

## WHY IT'S IMPORTANT

- STDs are the most commonly reported communicable diseases in Montana, with *Chlamydia trachomatis* being the most common.
- STDs are frequently asymptomatic. Chlamydial infections are especially asymptomatic, making continued screening of the utmost importance.
- Untreated or chronic chlamydial infections can progress to Pelvic Inflammatory Disease (PID). Pelvic inflammatory disease (inflammation of the reproductive organs) costs an estimated $7,500 to $15,000 per case, if a chlamydia infection progresses to PID. This condition can lead to infertility or tubal pregnancy.
- Testing and treatment are inexpensive. A test for chlamydia costs $12.69, and treatment only costs between $3 and $10. Both men and women can be tested for chlamydia infection.
- Young adults are diagnosed most frequently with chlamydia. Chlamydia disproportionately affects individuals between the ages of 15 to 24 years old with 78% of all cases occurring in this age group.

## WHAT MONTANA HAS ACCOMPLISHED

- Rates of the three most common STDs in Montana (syphilis, gonorrhea, and chlamydia) have been successfully reduced over the past 10 years through significant public health efforts.
- DPHHS supports 22 STD clinics statewide that provide access to testing and treatment for STDs and HIV status; 17 of these are also Title X Family Planning Clinics.
- Identifying sexual partners of infected persons is critical in reducing the incidence of STDs. The STD/HIV Section provides professional training, for both public and private health care providers, for STD interviewing and investigation.
- The STD/HIV Section collaborates on the Region VIII Infertility Prevention Project with Women's Health Section staff and local family planning clinics.

## WHAT STILL NEEDS TO BE DONE

- Increased screening activities and disease surveillance to identify chlamydia in all sectors of Montana health care providers.
- Testing and treating of all contacts named by the original patient, in order to identify the source patient, and any tertiary cases related to either the original patient or the contact.
- An increase in education, both public education and education provided the patient and their contacts, during the counseling session.
- Education surrounding primary and secondary disease prevention can be accomplished with collaboration between Federal, State, local county health, Indian Health Service, and Tribal health.
- Youth need a better understanding of STDs and better skills in delaying sexual activity or preventing STD transmission.

**For more information, contact**

**COMMUNICABLE DISEASE CONTROL AND PREVENTION BUREAU**

**STD/HIV Section**

**406/ 444-3565**

# SUICIDE PREVENTION

## GOAL AND OBJECTIVES

**Decrease the number of deaths in Montana from suicide.**

- To finalize the draft 5-year plan for suicide prevention in Montana by July 1, 2001
- To reduce the number of suicidal attempts in Montana among all ages from 18.6 per 100,000 (1986-1994) to 9.6 /100,000 by 2010.
- To reduce the number of firearm-related suicides in Montana from 118 in 1997 to 75 or less by 2005.
- To establish a central resource for Montanans to access technical assistance and training, "best practices" information, and updated listings of community resources by July 1, 2001.
- To provide a statewide crisis hotline that is accessible to every Montana citizen by telephone by July 1, 2002.
- To develop a grassroots system to promote suicide prevention by July 1, 2003.

Montanans place a high value on life. Thus, our citizens and organizations deal openly, collaboratively and with sensitivity towards all our cultures to minimize suicide as a choice made by any citizen.

## WHY IT'S IMPORTANT

- There is no coordinated statewide suicide prevention effort in Montana.
- Montana's overall suicide rate is among the highest in the nation.
- Suicide is the second leading cause of death for Montanans between the age of 10 -- 34 and the eighth leading cause of death in Montana for all ages.
- In Montana, men kill themselves 5 times more often than women, though women attempt suicide twice as often as men do.
- Suicide is the 2nd leading cause of death in Native American males before 54 years of age.
- Firearm-related suicide continues to be the leading cause of suicide in Montana, and is more common among males than females.
- Adolescent and young adult males are most at risk of dying from suicide.

## WHAT MONTANA HAS ACCOMPLISHED

1999 — DPHHS organized a State Suicide Prevention Steering Committee made of essential community partners from across the state.

2000 — The State Suicide Prevention Steering Committee published a draft version of *Suicide Prevention in Montana: A 5-Year Plan.* This plan addresses the environment for suicide prevention including:

- Montana's unique characteristics including assets and barriers.
- Resources and responsibilities necessary for accomplishment of the goals.

## WHAT STILL NEEDS TO BE DONE

- Secure ongoing funding to establish a Suicide Prevention emphasis within state government.
- Use services of the Regional Suicide Prevention Center in Nevada to study Montana data, evaluate current suicide prevention efforts in Montana, and make recommendations.
- 
- Finalize the 5-Year Suicide Prevention Plan.
- Prepare a directory of State agency and county- and reservation-specific resources in suicide prevention.

**For more information, contact:**

**FAMILY & COMMUNITY HEALTH BUREAU**
**Child, Adolescent and Community Health Section**

**406/ 444-4233**

**HEALTH SYSTEMS BUREAU**
**Emergency Medical Services and Injury Prevention Section**

**406/ 444-3895**

**DPHHS ADDICTIVE AND MENTAL DISORDERS DIVISION**

**406/ 444-3964**

# TOBACCO USE PREVENTION

## GOAL AND OBJECTIVES

**Reduce illness, disability, and death related to tobacco use and exposure to secondhand smoke.**

- To establish community-based tobacco use prevention programs in all Montana counties by 2005.
- To provide funding for all Montana Native American tribes and I.H.S.-recognized urban Indian Centers to develop tobacco use prevention programs by June 30, 2001.
- To implement tobacco use prevention education for students in grades K through 12 and at Montana's institutions of higher education, and to develop local community support for and enforcement of tobacco-free school policies in all Montana schools by June 2005.
- To develop, implement and evaluate a statewide media campaign to reduce tobacco use and exposure to secondhand smoke by June 30, 2001.
- To develop specially tailored programs to reduce the use of spit tobacco and to provide cessation programs and services to women of childbearing age by 2005.
- To leverage and maintain long-term funding for the Montana Tobacco Use Prevention Program (MTUPP) that is in accordance with the Centers for Disease Control and Prevention's recommended "Best Practices in Tobacco Control."

Tobacco use is epidemic in Montana. In 1998, 21%, or 1 of every 5 adult Montanans smoked cigarettes.[27]

*In 1999, 24% of high school students smoked, and one of every three (33%) high school boys used spit tobacco.*[28]

## WHY IT'S IMPORTANT

- Tobacco is a killer. More than 1,400 Montanans die prematurely from tobacco-related diseases every year. [29]
- Tobacco causes many diseases. Cigarette smoking causes heart disease, several kinds of cancer (lung, larynx, esophagus, pharynx, mouth and bladder) and chronic lung disease, and contributes to other cancers. [30] Smoking during pregnancy causes spontaneous abortions, low birth weights, and sudden infant death syndrome.
- Spit tobacco causes a number of serious oral health problems, including cancer of the mouth and gum, periodontitis, and tooth loss.[31]
- Nonsmokers suffer deadly consequences from exposure to secondhand smoke. Smoke from other people's cigarettes causes an estimated 3,000 lung cancer deaths and 50,000 heart and respiratory disease-related deaths each year among nonsmoking Americans. [32]
- Tobacco use is costly for all Montanans. DPHHS estimates that the Medicaid costs for illnesses related to tobacco use are more than $12 million each year in Montana. CDC estimates that the total annual cost of the tobacco health burden in Montana, from all public and private sources, is $153 million.[33]

## WHAT MONTANA HAS ACCOMPLISHED

- The 1999 Montana Legislature appropriated $7 million dollars from the state's settlement with the tobacco industry to the DPHHS MTUPP for the 2000-2001 biennium. Additionally, the MTUPP received $1.59 million in federal funding from CDC.
- In March 2000, the Governor's Advisory Council on Tobacco Use Prevention completed a comprehensive 5-year plan to guide the MTUPP.
- Contracted with 28 community-based entities to provide tobacco use prevention services in 40 counties.
- Contracted with seven tribal governments and all five I.H.S.-recognized urban Indian centers to implement tobacco use prevention programs.
- Conducted and evaluated a pilot media campaign on secondhand smoke issues.
- Established a Training and Technical Assistance Resource Center for community-based and Native American program contractors.
- Established a toll-free cessation quitline available to all Montana citizens.
- Funded the Office of Public Instruction to work with schools to establish tobacco-free school policies and provide tobacco use prevention education.
- Began pilot-testing a social norms marketing program to reduce youth initiation of tobacco products.
- Implemented the Young Adults Helping Others Understand (YAHOU) program to empower youth to be tobacco-free and promote tobacco-free lifestyles.
- Requested proposals for innovative and promising tobacco use prevention projects.
- Developed a comprehensive MTUPP surveillance and evaluation plan.

## WHAT STILL NEEDS TO BE DONE

- Ensure sustained, long-term funding for the MTUPP to continue and expand comprehensive tobacco use prevention programs at the state and community level.
- Strengthen state and local clean indoor air laws and develop viable mechanisms for enforcing all laws and policies regarding tobacco control.
- Increase the number of youth involved in local tobacco use prevention activities.
- Conduct statewide education programs to counter the acceptance of spit tobacco as an alternative to smoking tobacco.
- Provide long-term cessation reinforcement and assistance to ensure that mothers do not return to using tobacco products after childbirth.

**For more information, contact**

**HEALTH SYSTEMS BUREAU**

**Chronic Disease Prevention and Health Promotion Section**

**406/444-9020**

# WOMEN'S HEALTH and PREGNANCY

## GOAL AND OBJECTIVES

**Promote the health and well being of Montana women and ensure that pregnancies are intended and well timed.**

- To survey Native American women of childbearing age to assess their current reproductive health status by December 2001.
- To reduce the pregnancy rate for 15-17 year old Montana females to 27 per 1,000 by 2005. (Baseline: 32.1/1000) [34]
- To reduce the birth rate for 15-17 year old Montana females to no more than 18 per 1,000 by 2005. (Baseline: 19.8/1000) [35]
- To increase the proportion of health care providers who provide emergency contraception by 2005.
- To decrease the rate of very low birth weight births to 1.0% by 2005
- To decrease the infant mortality rate to 5.2 per 1,000 live births by 2005.

**Teen pregnancy is still a crisis despite rate decreases.**

Nationally,
49%
of all pregnancies are unintended.

*58%*
*of pregnancies among women aged 20 to 24 are unintended.*

*The financial impact of a poor pregnancy outcome is enormous. One day in a Montana neonatal intensive care unit costs $1,500 to $2,000.*

## WHY IT'S IMPORTANT

- An unintended pregnancy is, from the perspective of the woman, either unwanted or mistimed (occurring earlier than desired) at the time of conception. Nationally, 49% of all pregnancies are unintended.
- The majority of unintended pregnancies occur among adult women. About 31% of pregnancies among married women are unintended, as are 58% of pregnancies among women aged 20 to 24; 40% among ages 25-29; 33% among ages 30-34; and 41% among ages 35-39.[36] More than 51% of pregnancies among women age 40 and older are unintended. Among teens, 78% are unintended.[37]
- The consequences of a poor pregnancy outcome are profound and life threatening.

Mothers whose pregnancies are unintended:

- Are less likely to seek early prenatal care
- More likely to suffer abuse, depression and economic hardship
- More likely to use tobacco and alcohol

The family is more likely to have insufficient resources for a child's healthy development. There is an emotional and financial impact on the child, the family, and society as a whole.

Babies resulting from unintended pregnancies[38] are more likely to:

- Be born at low birthweight
- Suffer abuse
- As a fetus, more likely to be exposed to harmful substances such as tobacco and alcohol
- Have long-term, perhaps lifelong-health problems such as blindness, cerebral palsy, deafness, developmental delays, and other conditions affecting mobility or development.
- Die in their first year

## WHAT MONTANA HAS ACCOMPLISHED

- Helped prevent an estimated 18,680 unintended pregnancies in 1997 through Title X family planning services in communities throughout Montana.
- Implemented a Partnership Project with the Public Assistance Bureau and trained 181 local case managers with a goal of reducing unintended pregnancy among FAIM participants in 1999.
- Funded ten local communities to implement abstinence education programs. A statewide media campaign increased public awareness of the benefits of sexual abstinence until marriage.
- Provided clinical reproductive health updates in Montana for health care providers.
- Promoted educational offerings in conjunction with the national and regional Office of Women's Health.
- Continued to support perinatal education services that includes a toll-free hotline and distribution of materials to clients about healthy pregnancy practices.
- Participated in the research component of the Region VIII Family Planning Program social marketing campaign to prevent unintended pregnancy. Findings describe a program succeeding at its mission. Clients value the services being provided and feel supported and helped by local clinics
- Encouraged pregnant women to seek early prenatal care, to stop or decrease use of tobacco, drugs, and alcohol through statewide and local public education campaigns.
- Used public education multimedia campaigns to convey messages the importance of good health care during pregnancy, community services available, and health and safety risks to infants, children, and adolescents.
- Participated in funding and supporting services for high risk pregnant women through Public Health Home Visiting [also known as Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) and Follow Me.] These programs provide care coordination services for high risk pregnant women in 33 sites, including five reservations. In SFY 2000, MIAMI projects provided services to approximately 1600 high risk women ages 14-44 years.

## WHAT STILL NEEDS TO BE DONE

- Secure funding to maintain and expand family planning services to low-and marginal-income women in underserved areas of the state.
- Continue to gather data on the intendedness of pregnancies in Montana so that prevention efforts can be age-appropriate and culturally sensitive.
- Have Montana apply to HCFA for a Section 1115 waiver to expand Medicaid eligibility for family planning services.
- Implement the Region VIII social marketing plan in four local communities in Montana.
- Conduct family planning training for public health settings
- Continue to educate the public and providers about importance of early prenatal care and healthy habits prior to and during pregnancy
- Continue to evaluate home visiting programs and services in order to assure delivery of efficient, cost effective services

**For more information, contact**

**FAMILY AND COMMUNITY HEALTH BUREAU**

**Women's Health Section**

**406/444-3775**

**Child, Adolescent and Community Health Section**

**406/444-2606**

# APPENDICES

# HEALTHY PEOPLE 2010
# LEADING HEALTH INDICATORS

**THIS GUIDE LISTS WHERE THE TEN LEADING HEALTH INDICATORS HAVE BEEN INCORPORATED INTO THE MONTANA HEALTH AGENDA**

| | |
|---|---|
| Physical Activity<br>• Cardiovascular Health | Overweight and Obesity<br>• Cardiovascular Health |
| Tobacco Use<br>• Cardiovascular Health<br>• Oral Health<br>• Tobacco<br>• Women's Health & Pregnancy | Injury and Violence<br>• Injury Prevention<br>• Oral Health<br>• Suicide Prevention<br>• Women's Health & Pregnancy |
| Substance Abuse<br>• Cardiovascular Health<br>• Injury Prevention<br>• Women's Health & Pregnancy | Environmental Quality<br>• Food Safety<br>• Environmental Epidemiology<br>• Public Health Laboratory |
| Responsible Sexual Behavior<br>• Sexually Transmitted Diseases<br>• Women's Health & Pregnancy<br>• Public Health Laboratory | Immunization<br>• Immunizations<br>• Public Health Laboratory |
| Mental Health<br>• Suicide Prevention | Access to Health Care<br>• Access to Health Care<br>• Public Health Improvement<br>• Immunizations<br>• Oral Health<br>• Women's Health & Pregnancy |

# ACRONYMS, ABBREVIATIONS & GLOSSARY

| | |
|---|---|
| AARP | American Association of Retired Persons – a national organization whose membership is open to anyone 50 or more years of age. |
| ADAP | Ryan White Title II AIDS Drug Assistance Program, federal grant administered through DPHHS |
| AIDS | Acquired Immune Deficiency Syndrome |
| ALS | Advanced Life Support |
| ASTDD | Association of State & Territorial Dental Directors |
| BCHP | [DPHHS / HPSD] Breast & Cervical Health Program |
| Body Mass Index (BMI) | One of the most accurate ways to determine when extra pounds translate into health risks. BMI is a measure which takes into account a person's weight and height to gauge total body fat in adults. As of 6/98, a healthy weight is defined as a BMI of 24 or less. |
| CAH | Critical Access Hospital |
| CDC | [U.S.] Centers for Disease Control & Prevention |
| CDCPB | [DPHHS / HPSD] Communicable Disease Control & Prevention Bureau |
| CHC | Community Health Center |
| CHES | Community Health Education Specialist |
| CHIP | [DPHHS / HPSD] Children's Health Insurance Program |
| CON | Certificate of Need |
| COPD | Chronic Obstructive Pulmonary Disease |
| CSAP | [U.S.] Center for Substance Abuse and Prevention |
| CVD | Cardiovascular Disease |
| DEQ | [Montana] Department of Environmental Quality |
| DHHS | [U. S.] Department of Health & Human Services |
| DOT | [Montana] Department of Transportation |
| DPHHS | [Montana] Department of Public Health and Human Services |
| DTaP | Protects children against diphtheria, tetanus, and pertussis (whooping cough). DTaP is newer and is less likely to cause reactions. |

| | |
|---|---|
| Early Prenatal Care | Care within the first trimester of pregnancy |
| EMS | Emergency Medical Services |
| EPSDT | Early, Periodic, Screening, Diagnosis and Treatment – preventive health care for Medicaid-eligible children |
| FAIM | Families Achieving Independence in Montana – state welfare reform |
| FAS/FAE | Fetal Alcohol Syndrome / Fetal Alcohol Effect |
| FCHB | [DPHHS / HPSD] Family & Community Health Bureau |
| FDA | [U. S.] Food & Drug Administration |
| Federal Poverty Level | A simplification of the federal poverty threshold, used for administrative purposes in determining financial eligibility for certain federal programs, and designated by the year in which they are issued. For 2000, a family unit of 4 could earn no more than $17,050 (higher in Alaska and Hawaii). |
| FTE | Full time equivalent employee – typically a person who works 2080 hours per year. |
| GOAL | As used in this document, a brief statement of the intent or purpose of a particular program or effort. |
| HACCP | Hazardous Analysis Critical Control Point |
| HCFA | [U. S.] Health Care Financing Administration |
| Hep B | Hepatitis, Type B |
| Herd Immunity | Immunization based on the premise that if the majority of a population is immunized, those unimmunized will be protected. |
| Hib | Vaccine which protects children against Haemophilus Influenzae Type b (bacterial meningitis) |
| HIPAA | Health Insurance Portability and Accountability Act |
| HIV | Human Immunodeficiency Virus |
| HMHB | Healthy Mothers, Healthy Babies: the Montana Coalition |
| HMO | Health Maintenance Organization |
| HP 2010 | Healthy People [Objectives] for 2010 |
| HPSA | Health Professional Shortage Area – federal designation |
| HPSD | [DPHHS] Health Policy & Services Division |
| HRSA | [DHHS] Health Resources & Services Administration |
| HSB | [DPHHS / HPSD] Health Systems Bureau |
| IDEA | Integrated Data for Evaluation and Analysis |
| IHS | Indian Health Service |
| Low Birthweight | Weight of an infant that does not exceed 2500 grams, approximately 5# 8 oz. |
| MAF | Medical Assistance Facility |

| | |
|---|---|
| MCA | Montana Code Annotated – state laws<br>Montana Children's Agenda – a biennial publication of the Montana Council for Maternal & Child Health to guide policy makers about broad issues related to children and families |
| MCH | Maternal and child health |
| MCH BG | Maternal and Child Health Block Grant, Title V of the Social Security Act |
| MCHB | [U. S.] Maternal and Child Health Bureau – within DHHS |
| MCMCH | Montana Council for Maternal & Child Health, a 501(c) 4 organization that provides advocacy and lobbying services for a wide array of issues related to families and children. |
| MDA | Montana Dental Association |
| MDAC | Montana Dental Access Coalition |
| MDP | [DPHHS / HPSD] Montana Diabetes Program |
| MHA | Montana Hospital Association |
| MHC | Migrant Health Center |
| MIAMI | Montana's Initiative for the Abatement of Mortality in Infants – community based programs providing prenatal care access and information for high risk pregnant women |
| MMA | Montana Medical Association |
| MMR | Vaccine which protects children against Measles, Mumps, and Rubella |
| MPQHF | Mountain Pacific Quality Health Foundation – a private Montana-based health research, care review and data processing organization. |
| MSU | Montana State University |
| MTUPP | Montana Tobacco Use Prevention Program |
| MUA/P | Medically underserved area/population |
| NCHS | [U. S.] National Center for Health Statistics |
| NHSC | National Health Service Corps |
| OB/GYN | Obstetrician / Gynecologist |
| OPI | [Montana] Office of Public Instruction |
| Passport to Health | Managed care program for Medicaid-eligible persons |
| PCO | [DPHHS] Primary Care Office |
| PHDS | Public Health Data System |
| PHTI | [DPHHS] Public Health Training Institute |
| PID | Pelvic inflammatory disease |
| Primary Care Physician | This designation includes non-specialized family practice, internal medicine, pediatrics, general practice, and OB/GYN physicians. |

| | |
|---|---|
| RTACs | Regional Trauma Advisory Committees |
| R.N. | Registered nurse |
| RD | Registered dietitian |
| RHC | Rural Health Clinic |
| SCI | State Coverage Initiative |
| SEARCH | Student/Resident Experiences & Rotation in Community Health |
| Eat Right Montana | A statewide nutrition and physical activity coalition |
| SERVSAFE | Food safety training program |
| SFY | State Fiscal Year |
| SOPHI | Sharing of Public Health Information |
| STDs | Sexually transmitted diseases |
| TANF | Temporary Assistance for Needy Families |
| Td | Tetanus toxoid – a vaccine which protects persons against tetanus (lockjaw) |
| WFRS | Water Fluoridation Reporting System |
| WIC | Special Supplemental Nutrition Program for Women, Infants and Children |
| YAHOU | Young Adults Helping Others to Understand |

## MONTANA HEALTH RESOURCES AND COMMUNITY PARTNERS

[Unless otherwise noted, all telephone numbers use 406 prefix]

**This list is not exhaustive and does not include state agencies, DPHHS advisory councils, local or tribal health agencies, or hospitals. Additional resources are available from the DPHHS website: www.dphhs.state.mt.us and the Health Policy and Services Division website: www.dphhs.state.mt.us/hpsd/**

| *NAME OF ORGANIZATION* | *MAILING ADDRESS* | *PHONE* |
|---|---|---|
| American Academy of Pediatrics – Montana Chapter | c/o Karen Strickler, Exec Dir.<br>1500 Jerome Place<br>Helena 59601 | 442-3796 |
| American Cancer Society – Montana Division | 1 South Montana Avenue<br>Helena 59601 | 444-9300 |
| American College of OB/GYN – Montana Chapter | 925 Highland Blvd<br>Bozeman, MT 59715 | 587-9202 |
| American Diabetes Association – Montana Affiliate | 3203 3rd Avenue N<br>Billings 59101 | 256-0616<br>800-766-8596 |
| American Lung Association of the Northern Rockies | 825 Helena Avenue<br>Helena 59601 | 442-6556 |
| Arthritis Foundation of Montana | 1643 Lewis Avenue, Suite 3<br>Billings 59102-4151 | 245-0231 |
| Big Sky Chapter, March of Dimes | 643 Grand Avenue, Suite B<br>Billings 59101 | 252-7480 |
| Burns Telecommunications Center | PO Box 173860<br>Bozeman 59717-3860 | 994-6550 |
| Casey Family Program | 800 North Benton Avenue<br>Helena 59601 | 443-4730 |
| Childhood Lead Poisoning Prevention Project | c/o Butte-Silver Bow Health Department,<br>25 West Front Street Butte 59701 | 497-5040 |
| Critical Illness & Trauma Foundation | 300 North Willson Avenue<br>Suite 3002<br>Bozeman 59715 | 585-2659 |
| Eastern Montana Telemedicine Network | PO Box 3700<br>Billings 59107 | 657-4870 |
| Florence Crittenton Home | 901 North Harris<br>Helena 59601 | 442-6958 |
| Health Network | 11 South 7th ST, Suite 160<br>Miles City 59301 | 232-1420 |

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| *NAME OF ORGANIZATION* | *MAILING ADDRESS* | *PHONE* |
|---|---|---|
| Healthy Child Care Montana | c/o Missoula City-County Health Department<br>301 West Alder<br>Missoula 59801 | 523-4750<br>Ext. 3479 |
| Healthy Mothers, Healthy Babies: The Montana Coalition | PO Box 876<br>316 Fuller Avenue<br>Helena 59601 | 449-8611 |
| Indian Health Service – Billings Area Office | 2900 4th Avenue North<br>Billings 59101-1266 | 247-7107 |
| Intermountain Children's Home | 500 North Lamborn<br>Helena 59601 | 442-7920 |
| Lutheran Social Services | 501 Central, Suite 201<br>PO Box 1345<br>Great Falls 59403 | 761-4341<br>800-726-3082 |
| McLaughlin Research Institute | 1520 23rd Street South<br>Great Falls 59405 | 454-6009 |
| Mental Health Association of Montana | 25 South Ewing, Suite 200<br>Helena 59601 | 442-4276 |
| Montana Children's Alliance | PO Box 876<br>Helena 59624 | 443-1674<br>449-8611 |
| Montana Academy of Family Physicians | 2021 11th Avenue<br>Helena 59601 | 443-4000 |
| Montana Adoption Resource Center | 1 North Last Chance Gulch<br>Helena 59601 | 449-3266 |
| Montana Advocacy Program | PO Box 1681<br>316 North Park, Rm. 211<br>Helena 59624 | 444-3889 |
| Montana Alliance for the Mentally Ill | 324 Fuller<br>Helena 59601 | 443-7871 |
| Montana Area Health Education Center (AHEC) | 310 Culbertson Hall<br>PO Box 170520<br>Bozeman 59717-0520 | 994-6001 |

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| *NAME OF ORGANIZATION* | *MAILING ADDRESS* | *PHONE* |
|---|---|---|
| Montana Association of Counties (MACo) | 2711 Airport Road<br>Helena 59601 | 442-5209 |
| Montana Association of Health Care Purchasers | PO Box 4121<br>Missoula 59806 | 721-6275 |
| Montana Association of Home Health Agencies | PO Box 39<br>Polson 59860 | 883-7300 |
| Montana Association of WIC Agencies (MAWA) | c/o MT DPHHS<br>1400 Broadway<br>Cogswell Bldg., Rm. C-314<br>Helena 59620 | 444-5533 |
| Montana Campaign for Tobacco Free Kids | 538 Rollins Street<br>Missoula 59801 | 549-2120 |
| Montana Child Occupant Protection Project (COPP) | c/o Healthy Mothers, Healthy Babies<br>PO Box 876<br>316 Fuller Avenue<br>Helena 59601 | 449-8611 |
| Montana Coalition Against Domestic Violence | 32 South Ewing<br>Helena 59601 | 443-7794 |
| Montana Community Foundation | 101 North Last Chance Gulch<br>Helena 59601 | 443-8313 |
| Montana Community Partners | 34 North Last Chance Gulch<br>Helena 59601 | 888-599-2233 |
| Montana Council for Maternal and Child Health (MCMCH) | c/o Steve Yeakel<br>318 North Last Chance Gulch<br>Helena 59601 | 443-1674 |
| Montana Dental Access Coalition | c/o MT DPHHS<br>Cogswell Bldg., Rm. C-314<br>1400 Broadway<br>Helena 59620 | 444-0276 |
| Montana Dental Association | 318 North Last Chance Gulch<br>Helena 59601 | 443-2061 |
| Montana Family Practice Residency | 123 South 27th Street, Suite B<br>Billings 59101 | 247-3316 |

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| *NAME OF ORGANIZATION* | *MAILING ADDRESS* | *PHONE* |
|---|---|---|
| Montana Health Care Association | 36 South Last Chance Gulch<br>Helena 59601 | 443-2876 |
| Montana Healthcare Telecommunications Alliance (MHTA) | c/o MHA<br>PO Box 5119<br>Helena 59604 | 442-1911 |
| MHA. . .an association of health care providers | 1720 9th Avenue<br>Helena 59601 | 442-1911 |
| Montana Hunger Coalition | 5625 Expressway Lane<br>Missoula 59808-9071 | 327-9201 |
| Montana Rural Institute on Disabilities | University of Montana; 52 Corbin Hall<br>Missoula 59812 | 243-5467 |
| Montana League of Cities and Towns | 208 North Montana Avenue<br>Helena 59601 | 442-8768 |
| Montana Medical Association | 2021 11th Avenue<br>Helena 59601 | 443-4000 |
| Montana Medical Genetics Program | 2755 Broadway<br>Helena 59601 | 444-7530 |
| Montana Nurses' Association | 104 Broadway<br>Helena 59601 | 442-6710 |
| Montana Office of Rural Health | 304 Culbertson Hall<br>PO Box 170540<br>Bozeman 59717-0540 | 994-5553 |
| Montana Partners in Action | c/o MT Rural Development Partners<br>118 East Seventh Street, Suite 2A<br>Anaconda 59711 | 563-5259 |
| Montana Primary Care Association | 900 North Montana<br>Helena 59601 | 442-2750 |
| Montana Public Health Association | c/o Patrick Smith<br>25 South Ewing, Suite 416<br>Helena 59601 | 495-0515 |
| Montana Safe Kids Coalition | c/o Healthy Mothers, Healthy Babies<br>PO Box 876, 316 Fuller Avenue<br>Helena 59601 | 449-8611 |

## MONTANA HEALTH RESOURCES AND COMMUNITY PARTNERS

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| *NAME OF ORGANIZATION* | *MAILING ADDRESS* | *PHONE* |
|---|---|---|
| Montana Senior Citizens Association | 616 Helena Avenue<br>Helena 59601 | 443-5341 |
| Montana -Wyoming Tribal Leaders Council | 207 N. Broadway; Suite BR2<br>Billings, MT 59101-1951 | 252-2550 |
| Montana's Child Family Health Information Toll Free Line | c/o Healthy Mothers, Healthy Babies<br>PO Box 876, 316 Fuller Avenue<br>Helena 59601 | 800-421-6667 |
| Mountain Pacific Quality Health Foundation | 3404 Cooney Drive<br>Helena 59601 | 443-4020 |
| MSU College of Nursing | 115 Sherrick Hall, PO Box 173560<br>Bozeman 59717-3560 | 994-3784 |
| MSU Early Childhood Project | 114 Herrick, PO Box 173540<br>Bozeman 59717-3540 | 994-4746 |
| National Association of Social Workers, Montana Chapter | 25 South Ewing<br>Helena 59601 | 449-6208 |
| Rocky Mountain Laboratory | 903 South 4th Street<br>Hamilton 59840 | 363-3211 |
| Southwest MT Telepsychiatry Network | 50 South Last Chance Gulch, Suite 5<br>Helena 59604 | 447-2800 |

# SOURCES OF INFORMATION

## [ENDNOTES]

Following are the sources used in this document.

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1 *HEALTHY PEOPLE 2010: UNDERSTANDING AND IMPROVING HEALTH,* US Department of Health and Human Services, January 2000

2 Special thanks to Shari Pettit, Family and Community Health Bureau, DPHHS, who compiled the information from which this summary was prepared for Montana's MCH Block Grant application.

3 DPHHS sources

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22 Mokdad AH, et al. *Diabetes Care* 2000;23:1278-83.

23 Levetan C, Ratner R. The economic bottom line of preventive diabetes care. *Practical Diabetology 1995.*

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31 US DHHS, *The Health Consequences of Using Smokeless Tobacco*, HHS Pub. No. 86-2874, 1986.

32 National Cancer Institute, *Health Effects of Exposure to Environmental Tobacco Smoke,* Smoking and Tobacco Control Monograph No. 10, 1999

33 CDC, *State Tobacco Control Highlights - 1999*, p. 62

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36 *HEALTHY PEOPLE 2010: UNDERSTANDING AND IMPROVING HEALTH,* US Department of Health and Human Services, January 2000.

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## Priorities for a Healthy Montana:

- Cardiovascular Health
- Cancer Prevention
- Injury Prevention
- Women's Health & Pregnancy
- Child & Adolescent Health
- Diabetes Prevention & Control
- STD Prevention
- Tobacco Use Prevention
- Suicide Prevention
- Immunizations
- HIV/AIDS Treatment
- Food Safety
- Emergency Medical Services & Statewide Trauma Systems
- Access to Health Care
- Public Health Laboratory Services
- Public Health Improvement
- Information Access and Security
- Oral Health
- Environmental Epidemiology

MONTANA
Department of Public Health & Human Services

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